Madam Speaker, I thank Chairman Ridley and members of Augusta National for putting on a safe and memorable tournament this year.

And I want to extend my personal congratulations to the 2021 Masters Champion, Hideki Matsuyama. He is the first-ever Japanese professional golfer to win a men's major golf championship, and he has made his nation of Japan very proud.

Hideki is an inspiration to young golfers around the world, showing that you can reach the pinnacle of your profession through dedication and hard work.

HELPING YOUNG MOTHERS

(Mr. CASTEN asked and was given permission to address the House for 1 minute.)

Mr. CASTEN. Madam Speaker, earlier this month I visited Teen Parent Connection in Glen Ellyn, Illinois. It is an organization that serves young mothers, offering everything from diapers and formula, to doulas, counseling, and domestic abuse support services.

They were extremely grateful for the recent $1,400 economic impact payments that, in many cases, helped these new moms cover critical expenses like housing, food, and healthcare. But as we talked, it became apparent that they were not taking advantage and didn't even know about the larger $3,600 per child Child Tax Credit. And why would they? These are new moms that have never filed taxes before. They don't follow the tax policy changes nearly as closely as we do here in the Capitol, but here is this fantastic need.

Our office is now working to connect them with free tax filing services, but to the rest of American parents—young and old—please make sure to take advantage of this program. Even if you don't have any taxes due, the credit is fully refundable, and once you file, we will start sending checks to 70 million American families on July 1.

This tax credit will cut child poverty in half, help close the racial wealth gap, and help ensure more kids can live up to their full potential. In Illinois alone, it will lift 153,000 children out of poverty. It is, in short, a really big deal.

□ 0915

HONORING BETTY WIECHERT

(Mr. BALDERSON asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. BALDERSON. Madam Speaker, I rise today to honor the life of a lifelong Ohioan who made a profound impact on not only me but so many in the Zanesville area, my hometown, Betty Wiechert.

I first came to know Betty when I was just a young boy, when she became my first Sunday school teacher. All these years later, Betty and I still attended the same church together each Sunday.

Just a few weeks ago, Betty even surprised me by asking a question on a telephone townhall. She lived an incredibly full life until the very end.

Born in Newark and raised in Zanesville, Betty gave her entire life to her family and this community, teaching not only Sunday school but also third and fifth grades.

Her passing was preceded by her parents, her husband of nearly 62 years, Rudy, two grandchildren, two great-grandchildren, one great-great-grandchild, a brother-in-law, and her father-in-law and mother-in-law.

She is survived by six children, 16 grandchildren, 46 great-grandchildren, 42 great-great-grandchildren, with three more nephews, and extended family and friends.

Her faith and her positivity were Betty's trademarks and are all the things fellow Ohioans remember most about her.

I will miss seeing her each Sunday at church and will always admire her dedication to bettering the lives of those around her each day. We will miss her dearly.

WORKPLACE VIOLENCE PREVENTION FOR HEALTH CARE AND SOCIAL SERVICE WORKERS ACT

Mr. COURTNEY. Madam Speaker, as the designee of the chairman of the Committee on Education and Labor, pursuant to House Resolution 303, I call up the bill (H.R. 1195) to direct the Secretary of Labor to issue an occupational safety and health standard that requires covered employers within the health care and social service industries to develop and implement a comprehensive workplace violence prevention plan, and for other purposes, and ask for its immediate consideration.

The Clerk read the title of the bill.

The SPEAKER pro tempore (Mrs. DEMINGS). Pursuant to House Resolution 303, the amendment in the nature of a substitute recommended by the Committee on Education and Labor, printed in the bill, is adopted and the bill, as amended, is considered read.

The text of the bill, as amended, is as follows:

H.R. 1195

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Workplace Violence Prevention for Health Care and Social Service Workers Act''.

SEC. 2. TABLE OF CONTENTS.

The table of contents for this Act is as follows:

TITLE I—WORKPLACE VIOLENCE PREVENTION STANDARD

SEC. 101. WORKPLACE VIOLENCE PREVENTION STANDARD.

(a) INTERIM FINAL STANDARD.—

(1) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Secretary of Labor shall issue an interim final standard on workplace violence prevention—

(A) to require certain employers in the health care and social service sectors, and certain employers in sectors that conduct activities similar to the activities in the health care and social service sectors, to develop and implement a comprehensive workplace violence prevention plan and carry out other activities or requirements described in section 103 to protect health care workers, social service workers, and other personnel from workplace violence; and

(B) that shall, at a minimum, be based on the Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers published by the Occupational Safety and Health Administration of the Department of Labor in 2015 and adhere to the requirements of this title.

(2) INAPPLICABLE PROVISIONS OF LAW AND EXECUTIVE ORDER.—The following provisions of law and Executive orders shall not apply to the issuance of the interim final standard under this subsection:

(A) The requirements applicable to occupational safety and health standards under section 6(b) of the Occupational Safety and Health Act of 1970 (29 U.S.C. 655(b)).

(B) The requirements of chapters 5 and 6 of title 5, United States Code.

(C) Subchapter I of chapter 35 of title 44, United States Code (commonly referred to as the ''Paperwork Reduction Act'').

(D) Executive Order 12866 (58 Fed. Reg. 51735; relating to regulatory planning and review), as amended.

(3) NOTICE AND COMMENT.—Notwithstanding paragraph (2)(B), the Secretary shall, prior to issuing the interim final standard under this subsection, provide notice in the Federal Register of the interim final standard and a 30-day period for public comment.

(4) EFFECTIVE DATE OF INTERIM STANDARD.—The interim final standard shall—

(A) take effect on a date that is not later than 30 days after issuance, except that such interim final standard may include a reasonable phase-in period for the implementation of required engineering controls that take effect after such date;

(B) be enforced in the same manner and to the same extent as any standard promulgated under section 6(b) of the Occupational Safety and Health Act of 1970 (29 U.S.C. 655(b)); and

(C) be in effect until the final standard described in subsection (b) becomes effective and enforceable.

(5) FAILURE TO PROMULGATE.—If an interim final standard described in paragraph (1) is not issued not later than 1 year of the date of enactment of this Act, the provisions of this title shall be in effect and enforced in the same manner and to the same extent as any standard promulgated under section 6(b) of the Occupational Safety and Health Act (29 U.S.C. 655(b)) until such provisions are superseded in whole by an interim final standard issued by the Secretary that meets the requirements of paragraph (1).

(b) FINAL STANDARD.—

(1) PROPOSED STANDARD.—Not later than 2 years after the date of enactment of this Act, the Secretary of Labor shall, pursuant to section

6 of the Occupational Safety and Health Act (29 U.S.C. 655), promulgate a proposed standard on workplace violence prevention—

(A) for the purposes described in subsection (a)(1)(A); and

(B) that shall include, at a minimum, requirements contained in the interim final standard promulgated under subsection (a).

(2) FINAL STANDARD.—Not later than 42 months after the date of enactment of this Act, the Secretary shall issue a final standard on such proposed standard that shall—

(A) provide no less protection than any workplace violence standard adopted by a State plan that has been approved by the Secretary under section 18 of the Occupational Safety and Health Act of 1970 (29 U.S.C. 667), provided the Secretary finds that the final standard is feasible on the basis of the best available evidence; and

(B) be effective and enforceable in the same manner and to the same extent as any standard promulgated under section 6(b) of the Occupational Safety and Health Act of 1970 (29 U.S.C. 655(b)).

SEC. 102. SCOPE AND APPLICATION.

In this title:

(1) COVERED FACILITY.—

(A) IN GENERAL.—The term ''covered facility'' includes the following:

(i) Any hospital, including any specialty hospital, in-patient or outpatient setting, or clinic operating within a hospital license, or any setting that provides outpatient services.

(ii) Any residential treatment facility, including any nursing home, skilled nursing facility, hospice facility, and long-term care facility.

(iii) Any non-residential treatment or service setting.

(iv) Any medical treatment or social service setting or clinic at a correctional or detention facility.

(v) Any community care setting, including a community-based residential facility, group home, and mental health clinic.

(vi) Any psychiatric treatment facility.

(vii) Any drug abuse or substance use disorder treatment center.

(viii) Any independent freestanding emergency centers.

(ix) Any facility described in clauses (i) through (viii) operated by a Federal Government agency and required to comply with occupational safety and health standards pursuant to section 1960 of title 29, Code of Federal Regulations (as such section is in effect on the date of enactment of this Act).

(x) Any other facility the Secretary determines should be covered under the standards promulgated under section 101.

(B) EXCLUSION.—The term ''covered facility'' does not include an office of a physician, dentist, podiatrist, or any other health practitioner that is not physically located within a covered facility described in clauses (i) through (x) of subparagraph (A).

(2) COVERED SERVICES.—

(A) IN GENERAL.—The term ''covered service'' includes the following services and operations:

(i) Any services and operations provided in any field work setting, including home health care, home-based hospice, and home-based social work.

(ii) Any emergency services and transport, including such services provided by firefighters and emergency responders.

(iii) Any services described in clauses (i) and (ii) performed by a Federal Government agency and required to comply with occupational safety and health standards pursuant to section 1960 of title 29, Code of Federal Regulations (as such section is in effect on the date of enactment of this Act).

(iv) Any other services and operations the Secretary determines should be covered under the standards promulgated under section 101.

(B) EXCLUSION.—The term ''covered service'' does not include child day care services.

(3) COVERED EMPLOYER.—

(A) IN GENERAL.—The term ''covered employer'' includes a person (including a contractor, subcontractor, a temporary service firm, or an employee leasing entity) that employs an individual to work at a covered facility or to perform covered services.

(B) EXCLUSION.—The term ''covered employer'' does not include an individual who privately employs, in the individual's residence, a person to perform covered services for the individual or a family member of the individual.

(4) COVERED EMPLOYEE.—The term ''covered employee'' includes an individual employed by a covered employer to work at a covered facility or to perform covered services.

SEC. 103. REQUIREMENTS FOR WORKPLACE VIOLENCE PREVENTION STANDARD.

Each standard described in section 101 shall include, at a minimum, the following requirements:

(1) WORKPLACE VIOLENCE PREVENTION PLAN.—Not later than 6 months after the date of promulgation of the interim final standard under section 101(a), a covered employer shall develop, implement, and maintain an effective written workplace violence prevention plan (in this section referred to as the ''Plan'') for covered employees at each covered facility and for covered employees performing a covered service on behalf of such employer, which meets the following:

(A) PLAN DEVELOPMENT.—Each Plan shall—

(i) be developed and implemented with the meaningful participation of direct care employees, other employees, and employee representatives, for all aspects of the Plan;

(ii) be tailored and specific to conditions and hazards for the covered facility or the covered service, including patient-specific risk factors and risk factors specific to each work area or unit; and

(iii) be suitable for the size, complexity, and type of operations at the covered facility or for the covered service, and remain in effect at all times.

(B) PLAN CONTENT.—Each Plan shall include procedures and methods for the following:

(i) Identification of the individual and the individual's position responsible for implementation of the Plan.

(ii) With respect to each work area and unit at the covered facility or while covered employees are performing the covered service, risk assessment and identification of workplace violence risks and hazards to employees exposed to such risks and hazards (including environmental risk factors and patient-specific risk factors), which shall be—

(I) informed by past violent incidents specific to such covered facility or such covered service; and

(II) conducted with, at a minimum—

(aa) direct care employees;

(bb) where applicable, the representatives of such employees; and

(cc) the employer.

(iii) Hazard prevention, engineering controls, or work practice controls to correct hazards, in a timely manner, applying industrial hygiene principles of the hierarchy of controls, which—

(I) may include security and alarm systems, adequate exit routes, monitoring systems, barrier protection, established areas for patients and clients, lighting, entry procedures, staffing and working in teams, and systems to identify and flag clients with a history of violence; and

(II) shall ensure that employers correct, in a timely manner, hazards identified in any violent incident investigation described in paragraph (2) and any annual report described in paragraph (5).

(iv) Reporting, incident response, and post-incident investigation procedures, including procedures—

(I) for employees to report workplace violence risks, hazards, and incidents;

(II) for employers to respond to reports of workplace violence;

(III) for employers to perform a post-incident investigation and debriefing of all reports of workplace violence with the participation of employees and their representatives;

(IV) to provide medical care or first aid to affected employees; and

(V) to provide employees with information about available trauma and related counseling.

(v) Procedures for emergency response, including procedures for threats of mass casualties and procedures for incidents involving a firearm or a dangerous weapon.

(vi) Procedures for communicating with and training the covered employees on workplace violence hazards, threats, and work practice controls, the employer's plan, and procedures for confronting, responding to, and reporting workplace violence threats, incidents, and concerns, and employee rights.

(vii) Procedures for—

(I) ensuring the coordination of risk assessment efforts, Plan development, and implementation of the Plan with other employers who have employees who work at the covered facility or who are performing the covered service; and

(II) determining which covered employer or covered employers shall be responsible for implementing and complying with the provisions of the standard applicable to the working conditions over which such employers have control.

(viii) Procedures for conducting the annual evaluation under paragraph (6).

(C) AVAILABILITY OF PLAN.—Each Plan shall be made available at all times to the covered employees who are covered under such Plan.

(2) VIOLENT INCIDENT INVESTIGATION.—

(A) IN GENERAL.—As soon as practicable after a workplace violence incident, risk, or hazard of which a covered employer has knowledge, the employer shall conduct an investigation of such incident, risk, or hazard under which the employer shall—

(i) review the circumstances of the incident, risk, or hazard, and whether any controls or measures implemented pursuant to the Plan of the employer were effective; and

(ii) solicit input from involved employees, their representatives, and supervisors about the cause of the incident, risk, or hazard, and whether further corrective measures (including system-level factors) could have prevented the incident, risk, or hazard.

(B) DOCUMENTATION.—A covered employer shall document the findings, recommendations, and corrective measures taken for each investigation conducted under this paragraph.

(3) TRAINING AND EDUCATION.—With respect to the covered employees covered under a Plan of a covered employer, the employer shall provide training and education to such employees who may be exposed to workplace violence hazards and risks, which meet the following requirements:

(A) Annual training and education shall include information on the Plan, including identified workplace violence hazards, work practice control measures, reporting procedures, record keeping requirements, response procedures, anti-retaliation policies, and employee rights.

(B) Additional hazard recognition training shall be provided for supervisors and managers to ensure they—

(i) can recognize high-risk situations; and

(ii) do not assign employees to situations that predictably compromise the safety of such employees.

(C) Additional training shall be provided for each such covered employee whose job circumstances have changed, within a reasonable timeframe after such change.

(D) Applicable training shall be provided under this paragraph for each new covered employee prior to the employee's job assignment.

(E) All training shall provide such employees opportunities to ask questions, give feedback on training, and request additional instruction, clarification, or other followup.

(F) All training shall be provided in-person and by an individual with knowledge of workplace violence prevention and of the Plan, except that any annual training described in subparagraph (A) provided to an employee after the first year such training is provided to such employee may be conducted by live video if in-person training is impracticable.

(G) All training shall be appropriate in content and vocabulary to the language, educational level, and literacy of such covered employees.

(4) RECORDKEEPING AND ACCESS TO PLAN RECORDS.—

(A) IN GENERAL.—Each covered employer shall—

(i) maintain for not less than 5 years—

(I) records related to each Plan of the employer, including workplace violence risk and hazard assessments, and identification, evaluation, correction, and training procedures;

(II) a violent incident log described in subparagraph (B) for recording all workplace violence incidents; and

(III) records of all incident investigations as required under paragraph (2)(B); and

(ii)(I) make such records and logs available, upon request, to covered employees and their representatives for examination and copying in accordance with section 1910.1020 of title 29, Code of Federal Regulations (as such section is in effect on the date of enactment of this Act), and in a manner consistent with HIPAA privacy regulations (defined in section 1180(b)(3) of the Social Security Act (42 U.S.C. 1320d–9(b)(3))) and part 2 of title 42, Code of Federal Regulations (as such part is in effect on the date of enactment of this Act); and

(II) ensure that any such records and logs that may be copied, transmitted electronically, or otherwise removed from the employer's control for purposes of this clause omit any element of personal identifying information sufficient to allow identification of any patient, resident, client, or other individual alleged to have committed a violent incident (including the individual's name, address, electronic mail address, telephone number, or social security number, or other information that, alone or in combination with other publicly available information, reveals such individual's identity).

(B) VIOLENT INCIDENT LOG DESCRIPTION.—Each violent incident log shall—

(i) be maintained by a covered employer for each covered facility controlled by the employer and for each covered service being performed by a covered employee on behalf of such employer;

(ii) be based on a template developed by the Secretary not later than 1 year after the date of enactment of this Act;

(iii) include, at a minimum, a description of—

(I) the violent incident (including environmental risk factors present at the time of the incident);

(II) the date, time, and location of the incident, and the names and job titles of involved employees;

(III) the nature and extent of injuries to covered employees;

(IV) a classification of the perpetrator who committed the violence, including whether the perpetrator was—

(aa) a patient, client, resident, or customer of a covered employer;

(bb) a family or friend of a patient, client, resident, or customer of a covered employer;

(cc) a stranger;

(dd) a coworker, supervisor, or manager of a covered employee;

(ee) a partner, spouse, parent, or relative of a covered employee; or

(ff) any other appropriate classification;

(V) the type of violent incident (such as type 1 violence, type 2 violence, type 3 violence, or type 4 violence); and

(VI) how the incident was abated;

(iv) not later than 7 days after the employer learns of such incident, contain a record of each violent incident, which is updated to ensure completeness of such record;

(v) be maintained for not less than 5 years; and

(vi) in the case of a violent incident involving a privacy concern case, protect the identity of employees in a manner consistent with section 1904.29(b) of title 29, Code of Federal Regulations (as such section is in effect on the date of enactment of this Act).

(C) ANNUAL SUMMARY.—

(i) COVERED EMPLOYERS.—Each covered employer shall prepare and submit to the Secretary an annual summary of each violent incident log for the preceding calendar year that shall—

(I) with respect to each covered facility, and each covered service, for which such a log has been maintained, include—

(aa) the total number of violent incidents;

(bb) the number of recordable injuries related to such incidents; and

(cc) the total number of hours worked by the covered employees for such preceding year;

(II) be completed on a form provided by the Secretary;

(III) be posted for 3 months beginning February 1 of each year in a manner consistent with the requirements of section 1904 of title 29, Code of Federal Regulations (as such section is in effect on the date of enactment of this Act), relating to the posting of summaries of injury and illness logs;

(IV) be located in a conspicuous place or places where notices to employees are customarily posted; and

(V) not be altered, defaced, or covered by other material.

(ii) SECRETARY.—Not later than 1 year after the promulgation of the interim final standard under section 101(a), the Secretary shall make available a platform for the electronic submission of annual summaries required under this subparagraph.

(5) ANNUAL REPORT.—

(A) REPORT TO SECRETARY.—Not later than February 15 of each year, each covered employer shall report to the Secretary, on a form provided by the Secretary, the frequency, quantity, and severity of workplace violence, and any incident response and post-incident investigation (including abatement measures) for the incidents set forth in the annual summary of the violent incident log described in paragraph (4)(C). The contents of the report of the Secretary to Congress shall not disclose any confidential information.

(B) REPORT TO CONGRESS.—Not later than 6 months after February 15 of each year, the Secretary shall submit to Congress a summary of the reports received under subparagraph (A).

(6) ANNUAL EVALUATION.—Each covered employer shall conduct an annual written evaluation, conducted with the full, active participation of covered employees and employee representatives, of—

(A) the implementation and effectiveness of the Plan, including a review of the violent incident log; and

(B) compliance with training required by each standard described in section 101, and specified in the Plan.

(7) PLAN UPDATES.—Each covered employer shall incorporate changes to the Plan, in a manner consistent with paragraph (1)(A)(i) and based on findings from the most recent annual evaluation conducted under paragraph (6), as appropriate.

(8) ANTI-RETALIATION.—

(A) POLICY.—Each covered employer shall adopt a policy prohibiting any person (including an agent of the employer) from the discrimination or retaliation described in subparagraph (B).

(B) PROHIBITION.—No covered employer shall discriminate or retaliate against any employee for—

(i) reporting a workplace violence incident, threat, or concern to, or seeking assistance or intervention with respect to such incident, threat, or concern from, the employer, law enforcement, local emergency services, or a local, State, or Federal government agency; or

(ii) exercising any other rights under this paragraph.

(C) ENFORCEMENT.—This paragraph shall be enforced in the same manner and to the same extent as any standard promulgated under section 6(b) of the Occupational Safety and Health Act (29 U.S.C. 655(b)).

SEC. 104. RULES OF CONSTRUCTION.

Notwithstanding section 18 of the Occupational Safety and Health Act of 1970 (29 U.S.C. 667)—

(1) nothing in this title shall be construed to curtail or limit authority of the Secretary under any other provision of the law;

(2) the rights, privileges, or remedies of covered employees shall be in addition to the rights, privileges, or remedies provided under any Federal or State law, or any collective bargaining agreement; and

(3) nothing in this Act shall be construed to limit or prevent health care workers, social service workers, and other personnel from reporting violent incidents to appropriate law enforcement.

SEC. 105. OTHER DEFINITIONS.

In this title:

(1) WORKPLACE VIOLENCE.—

(A) IN GENERAL.—The term ''workplace violence'' means any act of violence or threat of violence, without regard to intent, that occurs at a covered facility or while a covered employee performs a covered service.

(B) EXCLUSIONS.—The term ''workplace violence'' does not include lawful acts of self-defense or lawful acts of defense of others.

(C) INCLUSIONS.—The term ''workplace violence'' includes—

(i) the threat or use of physical force against a covered employee that results in or has a high likelihood of resulting in injury, psychological trauma, or stress, without regard to whether the covered employee sustains an injury, psychological trauma, or stress; and

(ii) an incident involving the threat or use of a firearm or a dangerous weapon, including the use of common objects as weapons, without regard to whether the employee sustains an injury, psychological trauma, or stress.

(2) TYPE 1 VIOLENCE.—The term ''type 1 violence''—

(A) means workplace violence directed at a covered employee at a covered facility or while performing a covered service by an individual who has no legitimate business at the covered facility or with respect to such covered service; and

(B) includes violent acts by any individual who enters the covered facility or worksite where a covered service is being performed with the intent to commit a crime.

(3) TYPE 2 VIOLENCE.—The term ''type 2 violence'' means workplace violence directed at a covered employee by customers, clients, patients, students, inmates, or any individual for whom a covered facility provides services or for whom the employee performs covered services.

(4) TYPE 3 VIOLENCE.—The term ''type 3 violence'' means workplace violence directed at a covered employee by a present or former employee, supervisor, or manager.

(5) TYPE 4 VIOLENCE.—The term ''type 4 violence'' means workplace violence directed at a covered employee by an individual who is not an employee, but has or is known to have had a personal relationship with such employee, or with a customer, client, patient, student, inmate, or any individual for whom a covered facility provides services or for whom the employee performs covered services.

(6) THREAT OF VIOLENCE.—The term ''threat of violence'' means a statement or conduct that—

(A) causes an individual to fear for such individual's safety because there is a reasonable

possibility the individual might be physically injured; and

(B) serves no legitimate purpose.

(7) ALARM.—The term ''alarm'' means a mechanical, electrical, or electronic device that does not rely upon an employee's vocalization in order to alert others.

(8) DANGEROUS WEAPON.—The term ''dangerous weapon'' means an instrument capable of inflicting death or serious bodily injury, without regard to whether such instrument was designed for that purpose.

(9) ENGINEERING CONTROLS.—

(A) IN GENERAL.—The term ''engineering controls'' means an aspect of the built space or a device that removes a hazard from the workplace or creates a barrier between a covered employee and the hazard.

(B) INCLUSIONS.—For purposes of reducing workplace violence hazards, the term ''engineering controls'' includes electronic access controls to employee occupied areas, weapon detectors (installed or handheld), enclosed workstations with shatter-resistant glass, deep service counters, separate rooms or areas for high-risk patients, locks on doors, removing access to or securing items that could be used as weapons, furniture affixed to the floor, opaque glass in patient rooms (which protects privacy, but allows the health care provider to see where the patient is before entering the room), closed-circuit television monitoring and video recording, sight-aids, and personal alarm devices.

(10) ENVIRONMENTAL RISK FACTORS.—

(A) IN GENERAL.—The term ''environmental risk factors'' means factors in the covered facility or area in which a covered service is performed that may contribute to the likelihood or severity of a workplace violence incident.

(B) CLARIFICATION.—Environmental risk factors may be associated with the specific task being performed or the work area, such as working in an isolated area, poor illumination or blocked visibility, and lack of physical barriers between individuals and persons at risk of committing workplace violence.

(11) PATIENT-SPECIFIC RISK FACTORS.—The term ''patient-specific risk factors'' means factors specific to a patient that may increase the likelihood or severity of a workplace violence incident, including—

(A) a patient's treatment and medication status, and history of violence and use of drugs or alcohol; and

(B) any conditions or disease processes of the patient that may cause the patient to experience confusion or disorientation, be non-responsive to instruction, behave unpredictably, or engage in disruptive, threatening, or violent behavior.

(12) SECRETARY.—The term ''Secretary'' means the Secretary of Labor.

(13) WORK PRACTICE CONTROLS.—

(A) IN GENERAL.—The term ''work practice controls'' means procedures and rules that are used to effectively reduce workplace violence hazards.

(B) INCLUSIONS.—The term ''work practice controls'' includes—

(i) assigning and placing sufficient numbers of staff to reduce patient-specific type 2 violence hazards;

(ii) provision of dedicated and available safety personnel such as security guards;

(iii) employee training on workplace violence prevention methods and techniques to de-escalate and minimize violent behavior; and

(iv) employee training on procedures for response in the event of a workplace violence incident and for post-incident response.

TITLE II—AMENDMENTS TO THE SOCIAL SECURITY ACT

SEC. 201. APPLICATION OF THE WORKPLACE VIOLENCE PREVENTION STANDARD TO CERTAIN FACILITIES RECEIVING MEDICARE FUNDS.

(a) IN GENERAL.—Section 1866 of the Social Security Act (42 U.S.C. 1395cc) is amended—

(1) in subsection (a)(1)—

(A) in subparagraph (X), by striking ''and'' at the end;

(B) in subparagraph (Y), by striking the period at the end and inserting ''; and''; and

(C) by inserting after subparagraph (Y) the following new subparagraph:

''(Z) in the case of hospitals that are not otherwise subject to the Occupational Safety and Health Act of 1970 (or a State occupational safety and health plan that is approved under 18(b) of such Act) and skilled nursing facilities that are not otherwise subject to such Act (or such a State occupational safety and health plan), to comply with the Workplace Violence Prevention Standard (as promulgated under section 101 of the Workplace Violence Prevention for Health Care and Social Service Workers Act).''; and

(2) in subsection (b)(4)—

(A) in subparagraph (A), by inserting ''and a hospital or skilled nursing facility that fails to comply with the requirement of subsection (a)(1)(Z) (relating to the Workplace Violence Prevention Standard)'' after ''Bloodborne Pathogens standard)''; and

(B) in subparagraph (B)—

(i) by striking ''(a)(1)(U)'' and inserting ''(a)(1)(V)''; and

(ii) by inserting ''(or, in the case of a failure to comply with the requirement of subsection (a)(1)(Z), for a violation of the Workplace Violence Prevention standard referred to in such subsection by a hospital or skilled nursing facility, as applicable, that is subject to the provisions of such Act)'' before the period at the end.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply beginning on the date that is 1 year after the date of issuance of the interim final standard on workplace violence prevention required under section 101.

The SPEAKER pro tempore. The bill, as amended, shall be debatable for 1 hour equally divided and controlled by the chair and ranking minority member on the Committee on Education and Labor.

The gentleman from Connecticut (Mr. COURTNEY) and the gentlewoman from North Carolina (Ms. FOXX) each will control 30 minutes.

The Chair recognizes the gentleman from Connecticut.

GENERAL LEAVE

Mr. COURTNEY. Madam Speaker, I ask unanimous consent that all Members have 5 legislative days in which to revise and extend their remarks and include extraneous material on H.R. 1195, the Workplace Violence Prevention for Health Care and Social Service Workers Act.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Connecticut?

There was no objection.

Mr. COURTNEY. Madam Speaker, I yield myself such time as I may consume.

Madam Speaker, if there is one lesson that all Americans have learned in the last year from the shared experience of the COVID pandemic, it is that our Nation's healthcare workers have truly been heroic, putting their lives and health at risk, treating and caring for millions of patients suffering from a scary deadly disease. I am sure that every Member in this Chamber at some point has tweeted, issued statements, held up signs thanking nurses, EMTs, doctors, and many other caregivers for their amazing work.

But as all those brave workers can attest, there is a second colliding epidemic that they continue to face, namely, frightening levels of violence at rates that far exceed those faced by any other sector in our economy.

The Bureau of Labor Statistics, which has studied this alarming phenomenon, found that 73 percent of all violent incidents that happen in American workplaces happen to healthcare and social assistance employees. Year after year, BLS tallies tens of thousands of violent incidents which could be prevented by the standard required by today's legislation.

Today, we have the power right here in this Chamber to prevent this wave of violence by passing H.R. 1195, the Workplace Violence Prevention for Health Care and Social Service Workers Act.

The primary source of this violence comes in the form of assaults: kicking, hitting, spitting, even the use of firearms and other weapons from patients and those who accompany them.

H.R. 1195 would require an enforceable workplace violence prevention standard within 42 months after enactment at about 200,000 healthcare centers, not small doctors' offices or clinics. The standard would require that covered employers develop a workplace violence prevention plan that is tailored to the specific conditions and hazards present at each workplace, not a one-size-fits-all mandate.

Since 1996, OSHA has published voluntary guidelines that recommended many commonsense measures that employers can take to reduce the risk and severity of violent incidents. These guidelines are an excellent resource, but the fact that we continue to see an alarming growth in violence means that relying on ad hoc, voluntary adoption is failing to protect our healthcare heroes. We need an enforceable standard.

Over the last 5 years, in the last two administrations, despite verbal support for an enforceable OSHA rule, nothing has moved in the rulemaking process. History shows that with no deadlines in statute, OSHA takes 15 to 20 years to issue a standard.

Indeed, in the last administration, despite giving lip service for 3 years that they were creating a new rule, not one administrative step was actually taken to protect healthcare and social assistance workers.

I want to be very clear. Right now, over at that agency, this issue is dead in the water.

Every year we fail to address this situation, we are condemning thousands of nurses, doctors, aides, EMTs, and social workers to suffer preventable injuries, sometimes fatal, on the job.

That is why a huge coalition of healthcare workers from the American College of Emergency Physicians, National Nurses United, American Nurses Association, EMTs, and many more have come together, begging Congress to enact this bill.

No more delays. It is time that Congress puts a clock on this issue so that we can get the preventative measures in place nationwide that we know will save lives.

Madam Speaker, I want to thank the chair of the committee, Mr. SCOTT, for his great support on this measure, as well as Chair ADAMS, the Subcommittee on Workforce Protections chair, as well as my Republican colleagues, because there actually is some agreement on the basics on this issue.

Lastly, I want to thank our outstanding, stellar staff: Richard Miller; Jordan Barab, who is leaving us shortly, at the end of the month, for his incredible institutional knowledge and work; and Maria Costigan, from my office.

Madam Speaker, I reserve the balance of my time.

COMMITTEE ON ENERGY AND COMMERCE, HOUSE OF REPRESENTATIVES,
Washington, DC, March 26, 2021.

Hon. BOBBY SCOTT,
Chairman, Committee on Education and Labor, Washington, DC.

DEAR CHAIRMAN SCOTT: I write concerning H.R. 1195, the ''Workplace Violence Prevention for Health Care and Social Service Workers Act,'' which was additionally referred to the Committee on Energy and Commerce.

In recognition of the desire to expedite consideration of H.R. 1195, the Committee on Energy and Commerce agrees to waive formal consideration of the bill as to provisions that fall within the rule X jurisdiction of the Committee on Energy and Commerce. The Committee takes this action with the mutual understanding that we do not waive any jurisdiction over the subject matter contained in this or similar legislation, and that the Committee will be appropriately consulted and involved as this bill or similar legislation moves forward so that we may address any remaining issues within our jurisdiction. I also request that you support my request to name members of the Committee on Energy and Commerce to any conference committee to consider such provisions.

Finally, I would appreciate the inclusion of this letter in the report on the bill and into the Congressional Record during floor consideration of H.R. 1195.

Sincerely,

FRANK PALLONE, Jr.,
Chairman.

COMMITTEE ON EDUCATION AND LABOR, HOUSE OF REPRESENTATIVES,
Washington, DC, March 26, 2021.

Hon. FRANK PALLONE, Jr.,
Chairman, House Committee on Energy and Commerce, Washington, DC.

DEAR CHAIRMAN PALLONE: In reference to your letter of March 26, 2021, I write to confirm our mutual understanding regarding H.R. 1195, the ''Workplace Violence Prevention for Health Care and Social Service Workers Act.''

I appreciate the Committee on Energy and Commerce's waiver of consideration of H.R. 1195 as specified in your letter. I acknowledge that the waiver was granted only to expedite floor consideration of H.R. 1195 and does not in any way waive or diminish the Committee on Energy and Commerce's jurisdictional interests over this or similar legislation.

I would be pleased to include our exchange of letters on this matter in the committee report for H.R. 1195 and in the Congressional Record during floor consideration of the bill to memorialize our joint understanding.

Again, thank you for your assistance with these matters.

Very truly yours,

ROBERT C. ''BOBBY'' SCOTT,
Chairman.

Ms. FOXX. Madam Speaker, I yield myself such time as I may consume.

Madam Speaker, I thank my colleague for yielding.

Madam Speaker, I rise today in opposition to H.R. 1195, the Workplace Violence Prevention for Health Care and Social Service Workers Act.

Ensuring workplace safety for all American workers, especially our Nation's caregivers, is an issue of the utmost importance and is deserving of a serious and thorough solution. I agree with my colleague; we all appreciate what healthcare workers have done. I do every day, but particularly since we have had COVID.

H.R. 1195 purports to take a responsible approach to the issue of workplace violence, but legislation that results in a rushed and overly prescriptive rule that omits important input from stakeholders and experts, while driving up compliance costs for already struggling industries, is far from a sensible solution. Yet, that is what we are asked to consider today.

Workers in the healthcare and social services industries are at an increased risk of workplace violence, with the Bureau of Labor Statistics finding they are five times more likely to experience violence in the workplace than workers in other industries.

While the threat is real, the response the Democrats are proposing to address the situation, to further their own partisan agenda, is not grounded in reality.

Workplace violence is already a well-recognized hazard by employers and employees in the healthcare and social services industries. According to a 2018 American Hospital Association survey, 97 percent of respondents indicated they already have workplace violence policies in place.

In addition, the Occupational Safety and Health Administration, OSHA, is already enforcing workplace violence prevention measures, issuing citations to employers who fail to provide safe workplaces during both the Obama and Trump administrations.

The agency is also working on a rule through the standard OSHA rulemaking process and has announced plans to initiate a Small Business Regulatory Enforcement Fairness Act panel, a key part of the rulemaking process that allows the agency to gather valuable feedback from small businesses before a regulation is written.

H.R. 1195 is particularly ill-timed and ill-advised as it forces OSHA to issue an interim final rule on workplace violence within 1 year, which will significantly strain healthcare facilities that are heroically working on the front lines, responding to a once-in-a-century pandemic.

The CBO recently estimated the cost of this bill to private entities would be at least $1.8 billion in the first 2 years that the rushed OSHA rule is in effect and $750 million annually after that. The cost to public facilities will be at least $100 million in the first 2 years and $55 million annually after that.

Financially struggling healthcare facilities, such as rural hospitals that are already at risk of closure, cannot afford a rushed and costly government-imposed mandate from Washington bureaucrats.

The House is considering H.R. 1195 at a time when the Biden administration is also considering a burdensome, overreaching emergency temporary standard, ETS, on COVID–19. Though OSHA is weeks behind in deciding whether to issue the ETS, handing down two expensive, punitive Federal mandates on an already burdened healthcare industry could be the straw that breaks the camel's back.

There may be a time and place where a workplace violence regulation is appropriate, but now is certainly not it.

While I cannot support H.R. 1195, I want to be clear. The safety of our Nation's healthcare and social service workers is not a partisan issue. Republicans offered a workable solution at a recent committee markup and were willing to negotiate with our colleagues across the aisle on a compromise, one that requires OSHA to analyze a rule properly, heed appropriate and necessary input from stakeholders, and launch an educational campaign on workplace violence prevention.

Yet, here we are, considering another Democrat bill being pushed through with no Republican input.

Healthcare workers are familiar with the Hippocratic oath: ''First, do no harm.'' In its rush to judgment, H.R. 1195 does great harm. By short-circuiting the public input process and prescribing a specific result from the beginning, this bill will not achieve what it aims to accomplish.

Our healthcare workers and caregivers deserve an evidence-based and effective solution that protects them in the workplace. H.R. 1195 fails to deliver this result.

Madam Speaker, I reserve the balance of my time.

Mr. COURTNEY. Madam Speaker, I yield myself such time as I may consume. Very briefly, again, I appreciate that Ms. FOXX acknowledges the severity of this issue, and I think that is important. But I would note, if anyone checks with the House Clerk's office, we actually have a solid number of Republican cosponsors on this bill. I want to make that clear, for the record, and I appreciate their support as well.

Madam Speaker, I yield 2½ minutes to the gentleman from Virginia (Mr. SCOTT), the chair of the Committee on Education and Labor and an outstanding staunch supporter of this legislation.

□ 0930

Mr. SCOTT of Virginia. Madam Speaker, I thank the gentleman for yielding.

Madam Speaker, I rise in support of H.R. 1195, the Workplace Violence Prevention for Health Care and Social Service Workers Act.

Over the past year, we have voiced exceptional praise for healthcare and social service workers, who have risked their lives to care for ourselves and our loved ones. Yet, for too long, we have failed to address the high and growing rates of workplace violence for these workers, who are regularly beaten, kicked, punched, and sometimes even killed on the job.

In 2018, healthcare workers accounted for nearly three out of four of all nonfatal workplace injuries and illnesses caused by violence. Let me repeat that. In 2018, healthcare workers alone accounted for nearly three out of four of all nonfatal workplace injuries and illnesses caused by violence.

Many of these incidents are foreseeable and can be prevented by sound workplace violence prevention plans. They work, and when they are implemented, they can reduce workers' compensation claims.

Yet the Occupational Safety and Health Administration, or OSHA, still has no enforceable workplace standard that requires healthcare and social service employers to implement violence prevention programs. We have tried voluntary guidance for the past 25 years, yet still too many employers choose not to follow the best evidence on what is well understood to be authoritative guidance issued by OSHA.

To make matters worse, without action from Congress, protections for healthcare workers and social service workers are nowhere in sight. OSHA typically takes 7 to 20 years to issue a new standard. The recent beryllium standard that was adopted a couple of years ago was in the works for over 17 years.

We cannot ask healthcare and social service workers to wait any longer, particularly during this global pandemic when Congress has the ability to ensure that OSHA can act as quickly as possible to protect workers' lives.

The SPEAKER pro tempore. The time of the gentleman has expired.

Mr. COURTNEY. Madam Speaker, I yield an additional 30 seconds to the gentleman from Virginia.

Mr. SCOTT of Virginia. Madam Speaker, to that end, H.R. 1195 directs OSHA to issue an interim final standard within 1 year and a final standard within 42 months, requiring healthcare and social service employers to develop and implement a workplace violence prevention plan. It protects workers from retaliation for reporting assaults to their employers or government authorities. It also protects the employees of healthcare facilities run by State, county, or local governments in the 24 States that are not covered by either Federal OSHA or a State-run OSHA plan.

Madam Speaker, I commend the gentleman from Connecticut (Mr. COURTNEY) for his leadership, and I urge my colleagues to join us in voting for this legislation.

Ms. FOXX. Madam Speaker, I yield 2 minutes to gentleman from Pennsylvania (Mr. KELLER).

Mr. KELLER. Madam Speaker, my 25 years in private industry taught me many lessons. One which resonates with me today is that sweeping industry mandates with no input from those who will be impacted don't work. No one knows better what the workforce needs to be successful than the workforce itself.

It seems to me that my colleagues across the aisle have yet to learn this lesson and are rushing and pushing H.R. 1195, a bill that would institute a rushed, sweeping initiative that ignores the data and, more importantly, ignores the people it will effect.

Though H.R. 1195 is founded under the premise of finding solutions for workplace violence—especially for our healthcare workers and social service workers, who are most susceptible—this bill clearly misses the mark.

In tandem, the Occupational Safety and Health Administration also recognizes the risks that our healthcare and social service workers face in the workplace. However, this rulemaking process should and must account for the important views of impacted stakeholders.

There is not a more notable red flag to H.R. 1195 than the fact that the American Hospital Association came out to oppose it because it would institute additional restrictions to already struggling rural hospitals across the country. To ensure long-lasting policy that can address the complex problem of workplace violence, it is imperative we develop a solution that seeks input from stakeholders and employers that goes through the normal rulemaking process.

Our healthcare and social service workers have given so much during this pandemic, and we owe them a debt of gratitude for their work. Moreover, we owe them policy that will improve workplace safety without making it harder for them to do their jobs. We owe it to them to seek their input.

Mr. COURTNEY. Madam Speaker, I would just note that the bill language explicitly protects a comment period for all stakeholders, including hospitals and every other institution affected by it.

Madam Speaker, I yield 1 minute to the gentlewoman from North Carolina (Ms. ADAMS), who is the chairwoman of the Subcommittee on Workforce Protections and a staunch advocate for this bill.

Ms. ADAMS. Madam Speaker, I thank the gentleman from Connecticut for all his great work on this bill.

Madam Speaker, I rise in support of H.R. 1195.

As chair of the Committee on Education and Labor's Workforce Protections Subcommittee, I work every day to ensure that all workers are treated with dignity and respect because workers deserve nothing less. Our labor laws must be held to that same principle.

Unfortunately, our healthcare and social service workers face disproportionately high rates of violence on the job. We must do something to address that, and the Workplace Violence Prevention for Health Care and Social Service Workers Act does just that.

This critical piece of legislation requires that OSHA issue a workplace violence protection standard for employers in these sectors in order to actively prevent, address, and track workplace violence incidents.

We have always relied heavily on the selflessness of healthcare and social service workers, and that truth has been even clearer during the COVID pandemic. We must ensure their well-being just as they work tirelessly every day to ensure ours.

Madam Speaker, I urge support of H.R. 1195.

The SPEAKER pro tempore. The time of the gentlewoman has expired.

Mr. COURTNEY. Madam Speaker, I yield an additional 15 seconds to the gentlewoman from North Carolina.

Ms. ADAMS. Madam Speaker, I include in the RECORD letters from the American Society of Safety Professionals, who actively support this bill.

AMERICAN SOCIETY OF
SAFETY PROFESSIONALS,
March 25, 2021.

To: Contacts, Stakeholders and Participants Workplace Prevention Legislation [HR 1195]

From: Joseph Weiss, ASSP External Affairs

Comments of the American Society of Safety Professionals (ASSP)—The Workplace Violence Prevention for Health Care and Social Service Workers Act (HR 1309 & S 851)—Confirming ASSP's Position on HR 1195.

GREETINGS: The attached statement and comments were originally submitted by the American Society of Safety Professionals (ASSP) in support of The Workplace Violence Prevention for Health Care and Social Service Workers Act (HR 1309 & S 851) in April 2019.

We understand this legislation has been reintroduced as HR 1195. Our comments in the April 2019 statement remain current and reflect our position on HR 1195.

ASSP stands ready to assist with initiatives and endeavors to help move occupational safety and health forward. Please contact us if you have any questions regarding our support of HR 1195.

Thank you for your attention to this matter.

Cordially,

JOSEPH WEISS,
ASSP External Affairs.

AMERICAN SOCIETY OF
SAFETY PROFESSIONALS,
April 22, 2019.

Comments of the American Society of Safety Professionals (ASSP)—The Workplace Violence Prevention for Health Care and Social Service Workers Act (HR 1309 & S 851).

Hon. ALMA ADAMS,
House of Representatives: Committee on Education and Labor, Chair, Subcommittee on Workforce Protections, U.S. Congresswoman for the 12th District, Washington, DC.
Hon. BRADLEY BYRNE,
U.S. Congressman for the 1st District, House of Representative: Subcommittee on Workforce Protections, Washington, DC.
Hon. JOE COURTNEY,
U.S. Congressman for the 2nd District, Washington, DC.

The American Society of Safety Professionals (ASSP) is pleased to submit the following comments to the House Education and Labor Committee and the Senate Health Education Labor and Pensions Committee in support of HR 1309 and S. 851, legislation to help protect workers in the healthcare and social service sectors from the threat of workplace violence.

ASSP notes that this legislation has already secured nearly 60 co-sponsors in the House of Representatives and 8 cosponsors in the U.S. Senate. Because we believe that safety is a nonpartisan issue and that all of us benefit from the services the workers in these sectors deliver, we encourage bipartisan support of the legislation and additional public hearings on this critical issue.

ASSP is the oldest society of safety professionals in the world. Founded in 1911, ASSP represents more than 38,000 dedicated occupation safety and health (OSH) professionals. Our members are experts in managing workplace safety and health issues in every industry, in every state and across the globe. ASSP is also the Secretariat for various voluntary consensus standards related to best practices in occupational safety and health management and training.

In late October 2018, ASSP hosted the Women's Workplace Safety Summit, and workplace violence involving women was one of three focus topics of the event. Workplace violence has a disproportionate impact on women and is the leading cause of fatalities for workers who are women. ASSP's Women in Safety Excellence (WISE) Common Interest Group is also deeply engaged on the issue of workplace violence prevention.

ASSP commends your committees for addressing this issue through legislation that directs the Secretary of Labor to issue an OSH standard that requires covered employers within the healthcare and social service industries to develop and implement a comprehensive workplace violence prevention plan. If enacted, the legislation would ensure that enforceable and effective workplace violence prevention programs would be required within two years of enactment.

The Occupational Safety and Health Administration (OSHA) commenced a rulemaking by initiating a request for information (RFI) in December 2016: OSHA Request for Information Concerning Prevention of Workplace Violence in Healthcare and Social Assistance, OSHA Docket 2016–0014, Regulatory Information Number (RIN) 1218–AD 08. The comment period closed April 6, 2017. No further action has occurred since that date, despite workplace violence becoming an ever-more recognized hazard in the U.S.

ASSP submitted comments to OSHA on that RFI (at the time, the organization's name was American Society of Safety Engineers), and those comments are attached to this submission, along with an article from our ''HealthBeat'' publication, Preventing Workplace Violence, A Systematic & Systemic Approach, which was also submitted to the OSHA docket. We ask that these materials be formally included in the record on this legislation.

OSHA's November 2018 regulatory agenda included ''Prevention of Workplace Violence in Health Care and Social Assistance'' as a future item with a small business panel (pursuant to the Small Business Regulatory Enforcement Fairness Act) slated for March 2019. However, that date is now past with no action indicated any time in the foreseeable future. The next regulatory agenda will reveal whether any further action is anticipated by the agency within the next 12 months to move toward promulgation of a workplace violence standard.

Barring any movement from the agency in this regard, it is appropriate for Congress—in its oversight role—to signal to OSHA that this is a priority rulemaking area, and for your committees to take the lead on helping to fill the gaps in protections for the many vulnerable workers in this highrisk area.

Currently, OSHA can take enforcement actions against employers under its General Duty Clause (GDC) [Section 5(a)(1) of the Occupational Safety and Health Act of 1970] and can issue penalties of up to $132,598 per willful or repeated violation. However, OSHA has the burden of providing that the cited employer was aware of a recognized hazard, that employees were actually exposed to the hazard within the previous six months and that there is a feasible method of abatement.

GDC citations are often difficult for the agency to sustain, they cannot trigger criminal prosecution even in the case of a fatality, and there is no coverage for third-party workers such as contractors or temporary staffers. This is one exception to OSHA's multiemployer worksite enforcement policy. In 2015, OSHA issued ''Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers,'' but the guidance did not go through formal rulemaking so it is advisory and not enforceable at the present time.

Another problem with using the GDC as the main enforcement tool to address workplace violence issues is simply that it is reactive in virtually every situation. While OSHA investigates fatalities and cases with severe injuries that must be reported by law, it is virtually unheard of for OSHA to investigate an employer concerning workplace violence prevention before a tragic incident occurs, unless triggered by a publicized ''near miss'' or due to an employee hazard complaint.

While the federal Occupational Safety and Health Review Commission recently affirmed a GDC workplace violence violation issued against Integra Health Management (March 4, 2019, OSHRC), the action was taken only after the death of a healthcare worker at the hands of a patient, and the ultimate OSHA civil penalty was $7,000. The case is still subject to appeal in the U.S. Court of Appeals and amici curiae in the case include the U.S. Chamber of Commerce (opposing the enforcement action) and the AFL–CIO (in support of the OSHA citation). ASSP is not a party to this action.

A Government Accountability Office study reported that there were 730,000 cases of healthcare workplace assaults over the 5-year span from 2009 through 2013. The Bureau of Labor Statistics reports that healthcare and social service sector employees suffered 69 percent of all workplace violence injuries caused by persons in 2016 and are nearly 5 times as likely to suffer a workplace violence injury than workers overall.

The healthcare and social service industries experience the highest rates, with workplace violence injury rates for this sector at 8.2 per 10,000 full-time workers, more than four times higher than the overall private sector incidence rate for such injuries. This is simply unacceptable when interventions are available to mitigate risk. As noted in ASSP's 2016 comments to OSHA, we believe that a workplace violence prevention standard is feasible and that there are measures that employers can use to reduce a significant risk of material harm.

Finally, ASSP observes that many of the at-risk workers in the healthcare and social service sectors are employed in the public sector, by state or local government facilities or agencies. Currently, they have no protections under the federal Occupational Safety and Health Act. The states that operate their own OSHA agencies must cover their public sector workers (and several state governmental agencies in federal OSHA states also cover the safety of their public sector workers), but most workers go without OSHA protection. We urge you to consider including public sector coverage of healthcare and social service workers in this legislation to the extent possible.

CONCLUSION

ASSP condemns all forms of violence in the workplace and is particularly concerned with the rise of injuries associated with violence in the healthcare and social service industry sectors, targeted by the pending federal legislation. ASSP supports congressional efforts to eliminate workplace violence and encourages OSHA to continue with its rulemaking to promulgate an enforceable and effective standard, accompanied by comprehensive education and outreach.

Thank you for consideration of ASSP's comments. We look forward to working with Congress in a proactive manner to address the critical issues affecting the health and safety of all Americans in the workplace.

Respectfully Submitted,
RIXIO MEDINA, CSP, CPP,
2018–19 ASSP President.

Ms. FOXX. Madam Speaker, I yield 2 minutes to the gentleman from Georgia (Mr. ALLEN).

Mr. ALLEN. Madam Speaker, I rise in opposition to H.R. 1195.

Madam Speaker, our healthcare and social service workers deserve tremendous praise for their work over the past year, as they have faced unprecedented challenges during the COVID–19 pandemic. They also deserve protections, as they face a significant risk of workplace violence.

This complex issue deserves an evidence-based solution, not a rushed and costly top-down government mandate.

Unfortunately, H.R. 1195 would prevent workers and stakeholders from giving meaningful input based on experience regarding how to address this highly technical issue. It forces the Occupational Safety and Health Administration, or OSHA, to issue an interim final workplace violence prevention rule within 1 year, significantly impacting the healthcare industry as they remain on the front lines of combating this pandemic.

I have heard firsthand from our healthcare facilities—especially our rural hospitals—that the pandemic has caused serious financial struggles, and many are already at risk of closure.

The CBO estimates that the rushed rule will cost private entities at least $1.8 billion in the first 2 years that the

rule is in effect and $750 million annually after that. For public facilities, it will cost at least $100 million in the first 2 years and $55 million after that.

The last thing our healthcare facilities need right now is another costly top-down mandate from Washington.

Our Founders envisioned a government by the people. I am always amazed that the intellectuals in this town know more about solving problems than the great people on the front lines. My colleagues are approaching this issue the wrong way. We must address this from the bottom up by empowering healthcare workers, hospital leadership, the scientific community, and the public to have a say in the development of a new comprehensive standard.

That is why I oppose this bill today and I urge my colleagues to ensure our healthcare workers and caregivers are protected in the workplace by allowing them to give their input directly.

Mr. COURTNEY. Just to be clear, Madam Speaker, that CBO score is not per facility. That score is spread out over 200,000 healthcare centers. If you do the math, it is actually $9,000 per year per facility.

Madam Speaker, I yield 1 minute to the gentlewoman from Oregon (Ms. BONAMICI), who is the chair of the Subcommittee on Civil Rights and Human Services.

Ms. BONAMICI. Madam Speaker, I rise in support of the Workplace Violence Prevention for Health Care and Social Service Workers Act.

The coronavirus pandemic has exposed the increasingly harsh workplace conditions that nurses, doctors, social workers, and other healthcare workers have endured to keep our communities going. But even before the pandemic, healthcare and social service workers faced a disproportionate risk of on-the-job violence and injuries.

A few year ago, two workers in Oregon were tragically wounded in a workplace stabbing at an organization that provides essential services to youth who are facing addiction, homelessness, and behavioral health issues. Following the incident, Oregon AFSCME members organized to improve working conditions that were compromising the quality of services for vulnerable clients and the safety of the employees.

Workers across the country, like the workers at Outside In, in Portland, need an evidence-based workplace violence prevention plan tailored to the needs of the vulnerable populations they serve. Today, we have a chance to support their safety and well-being in the workplace.

Madam Speaker, I include in the RECORD a letter in support of the legislation from the Emergency Nurses Association.

EMERGENCY NURSES ASSOCIATION,
February 23, 2021.

Hon. JOE COURTNEY,
House of Representatives,
Washington, DC.

DEAR REPRESENTATIVE COURTNEY: On behalf of the Emergency Nurses Association (ENA) and our more than 52,000 members, I am writing to express our support for H.R. 1195, the Workplace Violence Prevention for Health Care and Social Service Workers Act of 2021. This important and timely legislation will ensure that health care and social service employers undertake steps to protect their employees and patients from violence in the workplace.

As you know, workplace violence against health care workers, including emergency nurses, has become a national crisis. According to the Occupational Safety and Health Administration (OSHA), workers in the health care sector accounted for only 20% of workplace injuries yet comprised approximately 50% of all victims of workplace assault. The same study found that between 2002 and 2013, serious incidents of workplace violence were four times more common for workers in the health care sector versus all workers in the U.S.

Unfortunately, assaults and batteries directed at workers occur at especially high rates in emergency departments (EDs), which are open 24 hours a day, seven days a week and are required under the Emergency Medical Treatment and Labor Act (EMTALA) to stabilize and treat all patients. Often, health care professionals in the ED interact with members of the public when emotions run high and their behavior can sometimes become violent. Research has found that emergency nurses and other personnel in the ED experience a violent event about once every two months. Further, a 2011 study reported that one-third of emergency nurses had considered leaving the profession due to workplace violence.

The Workplace Violence Prevention for Health Care and Social Service Workers Act will ensure that health care employers, including hospitals, take specific steps to prevent workplace violence and ensure the safety of patients and workers. This bill will require health care and social service employers to develop and implement a comprehensive violence prevention plan which must include procedures to identify and respond to risks that make workplaces vulnerable to violent incidents. In addition, the legislation will help ensure that employees are appropriately trained in mitigating hazards.

Emergency nurses are disproportionately victims of assaults in the workplace. We would like to thank you for introducing this important legislation and your leadership on this critical issue.

Sincerely,
RON KRAUS, MSN, RN, EMT, CEN, ACNS-BC, TCRN,
2021 ENA President.

Ms. BONAMICI. Madam Speaker, I thank Congressman COURTNEY for his leadership on this bill, and I urge my colleagues to support it.

Ms. FOXX. Madam Speaker, I yield 3 minutes to the gentleman from Virginia (Mr. GOOD).

Mr. GOOD of Virginia. Madam Speaker, memo to my friends across the aisle: violence, including workplace violence, is already illegal; and it should always be prosecuted, regardless of whether it happens in the name of Antifa or BLM, or even if it is directed at those police officers working to keep us safe.

Again, violence in the workplace is already illegal, and you certainly won't decrease it, Madam Speaker, with calls to defund or even eliminate law enforcement and correctional facilities.

Talk about increasing workplace violence, Madam Speaker, and you wonder why more Americans are purchasing firearms to protect themselves with the anarchy you seem to be promoting.

Speaking of law enforcement, do we actually want to protect police from workplace violence, too?

Or do we want to continue to increase it with a dishonest narrative that makes it more difficult for them to do their jobs and keep us all safe?

But here we find ourselves again today with our daily portion of proposed unnecessary workplace regulations intended to punish law-abiding American employers, making their lives more costly and more difficult.

Specific to those who would be most negatively impacted by this bill, in a 2018 American Hospital Association survey, 97 percent reported that they already have workplace violence prevention policies in place.

In addition, OSHA, of course, is already enforcing workplace violence prevention policies.

So why are we trying to saddle employers with new regulations estimated by the CBO to cost private entities at least $1.8 billion—that is $1,800 million, for my friends across the aisle—in just the first 2 years of mandated implementation, and then $750 million annually going forward?

Where does this money come from for these unnecessary mandates?

From consumers in higher prices. You might call this hidden tax increases. This is how all regulations are paid for, unless they actually force the organization to go out of business because they can't deal with the cost.

The CBO estimates that the cost to public healthcare facilities will be $100 million in the first 2 years. The last thing that financially struggling rural hospitals, like those in my district, need are more unfunded mandates from Washington.

While we seem to be far off course today, Congress, in the past, has actually passed statutes that make regulations more accountable, requiring that bureaucrats give public notice regarding new rules and mandates, and solicit feedback before implementation.

But, today, House Democrats want to make it easier for OSHA to issue one-size-fits-all regulations without having to receive any feedback from the public.

Article I of the Constitution mandates that Congress make our Federal laws, not Federal agencies and their unelected bureaucrats.

Congress should make the regulatory process more accountable to the taxpayer. That is why I introduced a bill called Article I Regulatory Budget Act that would require agencies to account for the cost of regulation.

The SPEAKER pro tempore. The time of the gentleman has expired.

Ms. FOXX. Madam Speaker, I yield an additional 15 seconds to the gentleman from Virginia.

Mr. GOOD of Virginia. In that spirit, Madam Speaker, I thank Ranking Member FOXX for her leadership on regulatory reform with her Unfunded

Mandates Accountability and Transparency Act. I am proud to stand with her as we try to shrink the size of the Federal Government and its negative impact on those we represent. So I oppose this bill.

□ 0945

Mr. COURTNEY. Madam Speaker, I yield 1 minute to the gentleman from Indiana (Mr. MRVAN), an outstanding new member of the Committee on Education and Labor.

Mr. MRVAN. Madam Speaker, I thank Mr. COURTNEY for the time.

First, I include in the RECORD this letter of support for H.R. 1195, the Workplace Violence Prevention for Health Care and Social Service Workers Act, written by Thomas Conway, the International President for the United Steelworkers.

UNITED STEELWORKERS,
March 24, 2021.

Re United Steelworkers supports H.R. 1195, the Workplace Violence Prevention for Health Care and Social Service Workers Act.

HOUSE OF REPRESENTATIVES,
Washington, DC.

DEAR REPRESENTATIVE: On behalf of the 850,000 members of the United Steelworkers (USW), I am urging you to support the Workplace Violence Prevention for Health Care and Social Service Workers Act (H.R. 1195).

Even before the COVID–19 pandemic, workplace violence in health care and social service settings was a growing and ever-present threat to workers. While helping patients fight against the virus, these workers, who repeatedly put their lives on the line to ensure the health and wellbeing of others, have had to face a continued rash of assaults and violent attacks.

According to data from the Department of Labor, healthcare employees are four times more likely to experience workplace violence than others in the private sector. And those in a hospital setting are nearly six times as likely as other workers to be the victim of an intentional injury. It is clear that these essential workers need protection against violence on the job. They need an enforceable OSHA standard to prevent workplace violence and ensure the safe working environment that they all deserve.

H.R. 1195 would compel OSHA to issue a workplace violence prevention standard that requires health care and social services employers to develop and implement comprehensive plans to protect workers from violence in the workplace. The requirements are based on existing guidelines and recommendations from OSHA, the National Institute for Occupational Safety and Health (NIOSH), industry associations, and state measures and ensure that there are workplace-specific plans in place to protect workers.

Violent, serious, and life-altering incidents should never be part of the job. In order to begin curbing this epidemic of preventable workplace violence, our health care and social service workers need an enforceable OSHA standard that addresses violence in the workplace in a comprehensive manner.

Our union urges you to support the Workplace Violence Prevention for Health Care and Social Service Workers Act (H.R. 1195).

Sincerely,

THOMAS CONWAY,
International President.

Mr. MRVAN. Madam Speaker, I appreciate that we are taking action today to support and defend these frontline workers, our healthcare and social workers, who selflessly have chosen their professions in order to serve others, and who, at the same time, experience rates of violence 12 times higher than other workers.

The United Steelworkers letter just inserted into the RECORD importantly noted that violent, serious, and life-altering incidents should never be a part of the job, and that in order to begin curbing this epidemic of workplace violence, our healthcare and social service workers need an enforceable OSHA standard that addresses violence in the workplace in a comprehensive manner.

There is a difference between punishment and safety, and I urge my colleagues to join me in supporting this critically important legislation for these invaluable workers.

Ms. FOXX. Madam Speaker, I yield myself such time as I may consume.

H.R. 1195 does not allow for a solid, well-researched foundation for a national workplace violence prevention standard. Input from experts and stakeholders is vital as OSHA undertakes rulemaking on this issue.

In February 2019, the Centers for Disease Control and Prevention, CDC, published its research agenda for healthcare and social assistance. The research agenda identifies the information and actions most urgently needed to improve safety in the industry.

The CDC identified the following concerns regarding the current state of research on the issue of healthcare workplace violence:

> Many existing studies have evaluated workplace violence risk factors and prevention measures, but most lack the comprehensive, facility- and work area-specific perspective that is needed to effectively prevent workplace violence. Additionally, many of these studies examine the effects of training programs, showing little impact on workplace violence incident and injury rates.

We should heed the words of caution from CDC regarding our current knowledge base, and we should make sure OSHA receives input from all perspectives, including smaller healthcare providers, before it enacts a national standard.

Madam Speaker, I reserve the balance of my time.

Mr. COURTNEY. Madam Speaker, I yield 2 minutes to the gentlewoman from Michigan (Ms. STEVENS), an outstanding member of the Committee on Education and Labor who worked very diligently to protect the comment process called for in this bill.

Ms. STEVENS. Madam Speaker, as I rise in support of the Workplace Violence Prevention for Health Care and Social Service Workers Act, I pose the question: Where were you, Madam Speaker, at 2 a.m. last night when a gunman stormed into a FedEx facility in Indianapolis killing eight colleagues who did not have a workplace safety plan because their phones were in their lockers, unable to text their loved ones that they were alive?

This is what we are asking our colleagues on the other side of the Chamber this morning as we debate this very important legislation. Because when you refuse to change the laws to enact gun safety in this country, when you refuse to enact a bill that will allow for workplace safety prevention plans to be put into place, you are simply accepting the status quo of the perpetuation of violence in our workplaces.

We are at a moment of crisis in this country when it pertains to gun violence. We have the testimonies of the doctors and the nurses. This has been extremely well-vetted.

Madam Speaker, I include in the RECORD a letter from National Nurses United in support of this legislation.

NATIONAL NURSES UNITED,
February 23, 2021.

DEAR REPRESENTATIVE: On behalf of the 170,000 registered nurses represented by National Nurses United, we write to urge you to cosponsor the Workplace Violence Prevention for Health Care and Social Service Workers Act, introduced by Representative Joe Courtney.

Across the country, registered nurses and other health care workers are put at risk every day when providing quality care for patients in need. Over the course of the past year, the dangerous working conditions in our nation's hospitals and health care facilities have been exposed due the Covid–19 pandemic. But these hazardous working conditions pre-date Covid–19.

The danger of violence in the workplace has become its own epidemic in our nation's health care and social service workplaces. In 2019, nurses reported more than three times the rate of injuries due to workplace violence than workers overall. Nurses report being punched, kicked, bitten, beaten, and threatened with violence as they provide care to others—and far too many have experienced stabbings and shootings.

Violence on the job has increased for nurses during the Covid–19 pandemic. According to a recent survey conducted by National Nurses United, twenty percent of nurses report facing increased workplace violence on the job over the course of the pandemic, which they attribute to decreasing staffing levels, changes in the patient population, and visitor restrictions.

There are practical steps that healthcare and social service employers can take to fulfill their obligations to protect their employees from these serious occupational hazards. We know that violence can be prevented through the development and implementation of plans that are tailored to specific patient care units and facilities. These plans must assess and address the range of risks for violence—from the sufficiency of staffing and security systems to environmental and patient-specific risk factors.

The Workplace Violence Prevention for Health Care and Social Service Workers Act mandates that the Occupational Safety and Health Administration promulgate a workplace violence prevention standard that would require healthcare and social service employers to develop and enforce plans to protect their employees from violence on the job. To ensure that workplace violence prevention plans are effective, workers (including nurses, other direct care employees, and security personnel) must be involved throughout all stages of plan development, implementation, and review, which go hand-in-hand with the standard's comprehensive training requirements. The enforceable occupational health and safety standard established in this legislation is necessary to create and maintain protections against workplace violence that our members, other

workers in healthcare and social settings, and, importantly, our patients deserve.

Last Congress, the Workplace Violence Prevention for Health Care and Social Service Workers Act was passed in the House of Representatives with bipartisan support. As nurses and other health care and social service workers continue to put their lives at risk to do their jobs, it is imperative that Congress pass this legislation and ensure it is signed into law.

Sincerely,

BONNIE CASTILLO, RN,
Executive Director, National Nurses United.
ZENEI CORTEZ, RN,
President, National Nurses United.
DEBORAH BURGER, RN,
President, National Nurses United.
JEAN ROSS, RN,
President, National Nurses United.

Ms. STEVENS. Workplaces need violence protection. Vote to pass H.R. 1195.

Ms. FOXX. Madam Speaker, I yield myself such time as I may consume.

As we have discussed today, workplace violence is a very real and persistent issue for healthcare and social service workers.

The Democrat title of H.R. 1195, the Workplace Violence Prevention for Health Care and Social Service Workers Act, presupposes that the rushed, overly prescriptive, and complex Federal regulation required by this bill will somehow prevent workplace violence.

However, a true solution to violence in the workplace will not be in the form of a Federal regulation. Rather, a broader, bipartisan approach is needed to address the root causes of this serious and complicated issue.

According to the American Hospital Association, increases in assaults in healthcare facilities are being driven, in part, by growing numbers of behavioral healthcare patients being treated in emergency departments and other acute-care settings.

The opioid and drug abuse epidemic is another major contributing factor to workplace violence, as healthcare workers are often tasked with treating patients that may be under the influence of potent drugs or experiencing their painful side effects.

Unfortunately, H.R. 1195 does nothing to address these realities.

Ultimately, an OSHA workplace violence regulation that is written under the standard rulemaking process will be much more informed and effective because it will require evidence-based input related to behavioral health and opioid abuse that are responsible for many workplace violence incidents.

But as I said earlier, we need to roll up our sleeves and develop a comprehensive, bipartisan response to address the root causes of this serious and complicated issue.

Again, I urge my colleagues to oppose H.R. 1195, and I reserve the balance of my time.

Mr. COURTNEY. Madam Speaker, I yield myself such time as I may consume.

First of all, I just want to compliment Ms. FOXX about her very thoughtful remarks about what is driving this crisis out there for healthcare workers. There is no question that behavioral health and the heroin and opioid addiction—and we heard this from witnesses who testified before our committee.

But I would respectfully suggest that the people who are actually out there on the front lines, the EMTs—their association has endorsed this bill—and the American College of Emergency Room Physicians—they are the ones right there taking in these very sort of high-risk, intense cases—have issued a letter of support for H.R. 1195 because they realize that what this bill will, in fact, create, is a safer system for better communication, better lighting, not leaving people alone with patients, who have been identified as high-risk.

Really, all you have to do is talk to any ER doc. They will tell you it is tough out there, and we need to change. We need to have systems in place to better protect them.

Madam Speaker, I include in the RECORD a letter of support from the American College of Emergency Physicians.

AMERICAN COLLEGE OF EMERGENCY PHYSICIANS,
March 23, 2021.

Hon. JOE COURTNEY,
Washington, DC.

DEAR REPRESENTATIVE COURTNEY: On behalf of the American College of Emergency Physicians (ACEP) and our 40,000 members, thank you for introducing for H.R. 1195, the Workplace Violence Prevention for Health Care and Social Service Workers Act. ACEP appreciates your leadership to help establish procedures to ensure that emergency physicians, health care workers, social workers, and patients, are protected from violence in the workplace, and we urge Congress to swiftly consider and pass this important legislation.

Violence in the emergency department is a serious and growing concern, causing significant stress to emergency department staff and to patients who seek treatment in the emergency department (ED). According to a survey conducted by ACEP in 2018, nearly half of emergency physicians polled reported being physically assaulted, with more than 60 percent of those occurring within the past year. Nearly 7 in 10 emergency physicians say ED violence has increased within the past 5 years. Beyond the immediate physical impacts, the risk of violence increases the difficulty of recruiting and retaining qualified health care professionals and contributes to greater levels of physician burnout. Most importantly, patients with medical emergencies deserve high-quality care in a place free of physical dangers from other patients or individuals, and care from staff that is not distracted by individuals with behavioral or substance-induced violent behavior.

There are many factors contributing to the increase in ED and hospital violence, and like you, we recognize there is no one-size-fits-all solution. Employers and hospitals should develop workplace violence prevention and response procedures that address the needs of their particular facilities, staff, contractors, and communities, as those needs and resources may vary significantly.

To this end, ACEP asks that Congress also take into consideration how emergency departments are staffed to ensure that the important provisions of this legislation are implemented in the most appropriate manner. As you are aware, emergency physicians may be employed in an ED in a variety of ways, whether directly employed through the hospital in an academic setting, or contracted as a member of a small democratic practice or a larger, national physician group. Given that emergency physicians and these groups do not control the resources of an individual facility that they staff, it would be neither practical nor effective to require contracted groups themselves to be responsible for implementing, tracking and reporting of violent incidents. ACEP believes that emergency physicians that contract with hospitals or facilities should not be held responsible for situations or hazards outside of their direct control; however, they can and should serve an integral role in developing effective violence prevention strategies. We appreciate your efforts to date to provide additional clarity on what a ''covered employer'' is ultimately responsible for, and ask Congress to ensure that any new federal requirements do not create any unintentional or undue burdens for entities that do not control the health care workplace.

Once again, thank you for your leadership on this important issue. ACEP looks forward to working with you to ensure patients, health care workers, and all others in the emergency department (ED) are prepared for and protected against violent acts occurring in the department.

Sincerely,
MARK ROSENBERG, DO, MBA, FACEP,
ACEP President.

Mr. COURTNEY. Madam Speaker, I yield 1 minute to the gentleman from Texas (Mr. GREEN), another outstanding supporter of this legislation.

Mr. GREEN of Texas. Madam Speaker, whatever employers are doing in the main is not enough. Workplace violence is the third leading cause of job death. Whatever they are doing is not enough.

Twenty percent of registered nurses in one survey reported an increase in workplace violence. Whatever they are doing is not enough.

It is not unreasonable to ask people to have a plan to protect employees. It is not unreasonable to ask them to enforce that plan. And it is not unreasonable to provide cover for those who report these workplace violence incidents in the form of protection from retaliation from reporting. It is just not enough.

Ms. FOXX. Madam Speaker, I reserve the balance of my time.

Mr. COURTNEY. Madam Speaker, I include in the RECORD a letter of support from AFT, which is a union that represents hundreds of thousands of frontline workers, including nurses, across the country in support of H.R. 1195.

AFT,
March 23, 2021.

HOUSE OF REPRESENTATIVES,
Committee on Education and Labor,
Washington, DC.

DEAR REPRESENTATIVE: On behalf of the 1.7 million members of the American Federation of Teachers, including nearly 200,000

healthcare professionals, I thank Chairman Bobby Scott for bringing H.R.1195, the Workplace Violence Prevention for Health Care and Social Service Workers Act, before the committee, and I urge you to vote in support of Congressman Joe Courtney's crucial legislation.

This bipartisan bill is straightforward and needed, requiring employers to develop violence prevention plans and establishing whistleblower protections so that healthcare and social service workers don't fear retaliation for speaking out against what they see in the workplace.

This is not an abstract issue for me. I hear from AFT healthcare members about violence all the time: a nurse choked to the point of unconsciousness, a nurse stabbed, members who have suffered bone fractures and brain injuries from being thrown against walls and floors. Subcommittee Chairwoman Alma Adams held an important hearing on workplace violence last Congress, where an AFT member shared the following:

He then spun around on his back and kicked his leg high into the air striking me in the neck, hitting with such force to my throat that my head snapped backward; I heard this ''bang'' and ''pop,'' and all the air just rushed out of me. . . . Since June 2015, I have been diagnosed with moderate to severe post-traumatic stress disorder, moderate anxiety, insomnia, depressive disorder and social phobia related to this incident. . . . I LOVED being a nurse. I have a huge problem still calling myself a nurse. I do not know what to call myself now. There is a deep loss when you used to make a difference in the lives of people, in your true calling and with passion. Now, that space is filled with extreme sadness and fear. . . . I lost my career.

Violence is not just ''part of the job.'' No one should face violence, intimidation or fear for their safety while working to heal others and save lives. Sadly, healthcare and social service workers are nearly five times more likely to be assaulted while on the job than the rest of our workforce. The costs of this violence are high: in injury rates, in professionals being driven from doing the work they love, and in workers' compensation claims and staff shortages.

Our nurses, health techs, social service workers and other health professionals need more than nightly applause; they need enforceable federal protections to keep them safe from the epidemic of workplace violence and other serious hazards they face at work. These are the people who take care of us when we need them, who have devoted their careers to looking after the aging, the sick and the injured, but are forced to beg Congress for basic workplace rights.

I urge you to support the nurses, social workers and other healthcare professionals in your district by voting for committee approval of the Workplace Violence Prevention for Health Care and Social Service Workers Act.

Sincerely,

RANDI WEINGARTEN,
President.

Mr. COURTNEY. Madam Speaker, I yield 1 minute to the gentleman from Rhode Island (Mr. CICILLINE), my neighbor and good friend.

Mr. CICILLINE. Madam Speaker, our Nation owes a great debt to the healthcare and social service workers fighting on the frontlines of the COVID–19 pandemic. These essential workers treat the ill, administer vaccines, care for the elderly, and respond to emergencies across the country. Their efforts are critical to our Nation's response to the pandemic.

Yet, Congress has abdicated its responsibility to protect these essential workers from violence in the workplace. These workers are almost five times as likely to experience a serious injury from workplace violence than workers in other sectors.

That is why I am proud to cosponsor H.R. 1195. I want to acknowledge the principled, compassionate, committed and effective leadership of Congressman COURTNEY for shepherding this bill to the floor.

This legislation would direct OSHA to quickly issue an interim final standard mandating healthcare and social service employers implement workplace prevention plans.

This is not a partisan issue. I hope we can all agree that everyone deserves to feel safe at work. I urge my colleagues to vote ''yes.''

Madam Speaker, I include in the RECORD a letter from the American Public Health Association in support of the legislation.

AMERICAN PUBLIC
HEALTH ASSOCIATION,
Washington, DC, March 23, 2021.

HOUSE COMMITTEE ON EDUCATION AND LABOR,
Washington, DC.

DEAR REPRESENTATIVE: On behalf of the American Public Health Association, a diverse community of public health professionals that champions the health of all people and communities, I write in strong support of H.R. 1195, the Workplace Violence Prevention for Health Care and Social Services Workers Act. This important bipartisan legislation would require the Occupational Safety and Health Administration to develop a workplace violence prevention standard to protect workers who are at the greatest risk from violence on the job.

Workplace violence is a serious problem that has increased substantially in the last decade. Every day, nurses, psychiatric aides, social workers and other caretakers are assaulted on the job. The Bureau of Labor Statistics reports that in 2019 health care and social service workers experienced the highest rate of workplace violence injuries at 14.7 per 10,000 workers, compared to a national average of 4.4 for all workers. In the same year, psychiatric hospitals had a recorded rate of serious injury due to workplace violence at 152.4 per 10,000 workers. Since 2010, the rate of serious workplace violence injuries has increased by 52% in health care and social assistance jobs. Health care and social service workers are at greatest risk because they are on the frontlines of patient and client care, often working with high-risk populations who need specialized care and attention. This type of violence has a significant and long-lasting impact on individual workers and on the public's health.

Assaults and other violence experienced by health care and social assistance workers is a preventable problem that requires a public health approach. This legislation would require employers who operate health care facilities, mental health clinics, emergency services and home care to develop a workplace violence prevention plan. These plans have shown to be effective and the tools for preventing violence in these workplaces are available, such as emergency response alarms, improved lighting and safe staffing levels.

We strongly urge your support for this important legislation which is a critical step in protecting our caregivers from work-related violence.

Sincerely,

GEORGES C. BENJAMIN, MD,
Executive Director.

Ms. FOXX. Madam Speaker, I yield myself such time as I may consume.

Madam Speaker, the American Hospital Association, AHA, is opposed to H.R. 1195.

In a letter to Education and Labor Committee members prior to the committee markup last month, AHA stated: ''However, because hospitals have already implemented specifically tailored policies and programs to address workplace violence, we do not believe that the OSHA standards required by H.R. 1195 are warranted, nor do we support an expedited approach that would deny the public the opportunity to review and comment on proposed regulations.''

Further, AHA explained:

The prohibitive costs that the mandates in H.R. 1195 would impose on America's hospitals, particularly on those that provide care in rural and underserved areas, could strain scarce resources and jeopardize patient care.

These mandates would burden healthcare providers that are struggling to maintain services during the most deadly public health emergency in 100 years.

Madam Speaker, I include in the RECORD the letter from the American Hospital Association.

AMERICAN HOSPITAL ASSOCIATION,
Washington, DC, March 23, 2021.

Hon. JOE COURTNEY,
House of Representatives,
Washington, DC.

DEAR REPRESENTATIVE COURTNEY: On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our clinician partners—including more than 270,000 affiliated physicians, 2 million nurses and other caregivers—and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) writes regarding the Workplace Violence Prevention for Health Care and Social Service Workers Act (H.R. 1195).

Your bill would direct the Secretary of Labor to issue—on an expedited timetable—and Occupational Safety and Health Administration (OSHA) standard requiring employers in health care and social services to develop and implement a comprehensive workplace violence prevention plan. America's hospitals and health systems are committed to a culture of safety for every worker, patient and family member who enters our facilities. However, because hospitals have already implemented specifically tailored policies and programs to address workplace violence, we do not believe that the OSHA standards required by H.R. 1195 are warranted, nor do we support an expedited approach that would deny the public the opportunity to review and comment on proposed regulations.

Further, the prohibitive costs that the mandates in your bill would impose on America's hospitals, particularly on those that provide care in rural and underserved areas, could strain scarce resources and jeopardize patient care. These mandates would burden health care providers that are struggling to maintain services during the most deadly public health emergency in 100 years. For these reasons, we must oppose H.R. 1195 and urge the Committee on Education and Labor not to report it favorably.

H.R. 1195 WOULD IMPOSE BURDENSOME UNFUNDED MANDATES AND PROHIBITIVE COSTS ON HOSPITALS

According to the Congressional Budget Office's (CBO) estimate of your bill in 2019, in the first two years in which the OSHA final rule would be in effect, the cost to private entities would be at least $2.7 billion and at least $1.3 billion each year thereafter.

CBO concluded that ''substantial personnel and capital costs would be imposed by the requirements for training, investigation, engineering, and infrastructure changes.'' Such costs are unsustainable. A recent report by Kaufman-Hall forecasts that total hospital revenue in 2021 could be down between $53 billion and $122 billion from pre-pandemic levels. In addition to lost revenue, hospitals must absorb increases in many expenses due to COVID–19. These losses come on top of the historic financial crisis that hit the hospital field last year, with an AHA report estimating total losses for the nation's hospitals and health systems to be at least $323 billion through 2020.

HOSPITALS ALREADY STRIVE TO PREVENT VIOLENCE IN THE WORKPLACE

Hospitals and health systems depend on compassionate, skilled, trained, and dedicated men and women to support and carry out their core mission of caring for people. As a result, they view the safety and well-being of employees as a top priority and take seriously their responsibilities to ensure a safe workplace free of all forms of violence—whether such violence results from encounters between staff and patients and/or their families, staff-to-staff aggression and harassment, or the intrusion of community conditions and community violence into the workplace. Hospitals are focused on violence prevention within their facilities and in the communities they serve.

To support hospitals' efforts, the AHA has implemented a cross-association effort to develop tools and resources to highlight and share with the field numerous programs and resources to combat violence within the hospital and the community. We have encouraged OSHA to support hospitals' efforts by sponsoring research to identify best practices for various workplace settings and circumstances and widely disseminating information about these proven best practices to the health care field.

Hospitals have established organization-wide initiatives to address workplace violence. As the most recent Hospital Security Survey conducted in 2018 by AHA's Society for Healthcare Engineering and Health Facilities Management reveals, workplace violence policies are in place for 97% of respondent facilities and 95% have active-shooter policies. Further, nearly three-quarters of hospitals responding (72%) conduct security risk assessments at least annually, with almost half using a combination of in-house and outside security experts to conduct these assessments. Moreover, in response to the increasing challenges of maintaining secure environments, a majority of hospitals are using aggressive management training as a proactive way to prevent the occurrence of security incidents and to be better prepared to respond effectively when incidents arise.

A majority of hospitals, working in tandem with security officers and front-line staff, have adopted programs to train all clinical staff to de-escalate security situations before they erupt. Hospitals have created these programs in-house and tailored them to their particular needs. For example, Boston Medical Center (BMC), a 500-bed, 41-building hospital located close to a county jail, a homeless shelter and a methadone clinic, developed its own de-escalation program. BMC's training focuses on verbal de-escalation and physical restraint skills. All frontline staff-unit clerk nurses, intensive care unit staff, social workers, etc.,—along with security staff receive ongoing training at BMC. Scenario training uses videos that re-enact possible active-shooter security incidents; these BMC videos are available for other hospitals to access as training tools. Another example is that of Atrium Health, which has created its in-house training program. Staff members certified in workplace violence prevention train other staff members, including home health workers, using a multi-tiered program.

As the association representing hospitals and health systems nationwide, the AHA is committed to helping our members prevent and reduce violence. We have established a specific initiative focused on combatting violence in all its forms. A critical component of this initiative includes developing tools and resources to highlight and share with the hospital field programs, initiatives and other efforts to help combat violence at hospital facilities as well as in the communities served by the hospital. We have developed a dedicated webpage to share information and resources that address everything from conducting a risk assessment to emergency response best practices, and we encourage all hospitals to use these resources to expand and strengthen their own violence prevention efforts.

On the website, hospitals can find the Healthcare Facility Workplace Violence Risk Assessment Tool developed by the AHA's American Society for Healthcare Risk Management to offer practical guidance for those charged with overseeing hospital security and facilities management. Also on the website is Guiding Principles for Mitigating Violence in the Workplace, a resource created jointly by the American Organization for Nursing Leadership (an AHA-affiliated organization) and the Emergency Nurses Association. The resource outlines guiding principles and priorities to systematically reduce lateral as well as patient and family violence in the workplace. In addition, an article from Health Facilities Management encourages and guides health care organizations in consulting with security personnel during design of new facilities to incorporate workplace safety considerations as a fundamental component of these construction projects.

FEDERAL POLICYMAKERS SHOULD FOCUS ON DISSEMINATION OF BEST PRACTICES TO THE FIELD AND SUPPORT INCREASED FUNDING FOR BEHAVIORAL HEALTH CARE

Hospitals' efforts to curb workplace violence would be bolstered by robust federal initiatives that would disseminate health care and social assistance sectors best practices that have demonstrated effectiveness in violence prevention. Federal support of research to identify the effectiveness of best practices for different workplace settings and circumstances and disseminating information about such best practices would do more to advance and promote workplace safety than the adoption of a ''one-size-fits-all'' standard for compliance and enforcement. The establishment of a uniform workplace violence standard for the field may lead to organizations using a narrowly focused and thereby less effective compliance strategy in addressing the problem of workplace violence.

We note evidence suggesting that increases in assaults in the health care workplace are being driven, in part, by growing numbers of behavioral health care patients reporting to and being treated in emergency departments and other settings in acute care, general hospitals. Another security challenge is the opioid epidemic, which continues to affect communities nationwide.

Integrating mental health, substance use disorder, and primary care services has proven to produce the best outcomes and to be the most effective approach to caring for people with multiple health care needs. But at the same time, funding for behavioral health treatment for such patients is being stripped, and it can be difficult for health care organizations to find the financial, staffing, and other resources needed to fully address issues associated with caring for them.

For these reasons, we believe there are productive actions Congress can take to help stem workplace violence in hospitals and health systems. We urge Congress to significantly increase funding for expanded and improved delivery of behavioral health care, and to support the hospital field's efforts to secure necessary funds to share best practices and approaches, expand educational programs, and make other investments in safety. We must address the root causes of the negative workplace safety issues that have arisen as a result of continued underfunding of treatment and service delivery for growing numbers of behavioral health care and opioid-dependent patients in emergency departments and other acute care hospital settings.

We believe that these approaches would help mitigate workplace violence and aid hospitals and health systems in further addressing these incidents through policies and strategies that are best suited to their needs and the needs of the communities they serve. We stand ready to work with you to explore an appropriate congressional response that would improve hospitals' ability to address workplace violence.

Sincerely,

THOMAS P. NICKELS,
Executive Vice President.

Ms. FOXX. Madam Speaker, we are hearing from the people who are on the front lines, and we have said we want to protect the people on the front lines. Well, let's listen to the people on the front lines.

I reserve the balance of my time.

Mr. COURTNEY. Madam Speaker, really quick, on page 11 of the bill it specifically states that the plans proposed to be adopted by OSHA would ''be tailored and specific to conditions and hazards for the covered facility or the covered service, including patient-specific risk factors and risk factors specific to each work area or unit.'' That is not one size fits all.

Madam Speaker, I yield 2 minutes to the gentlewoman from Texas (Ms. GARCIA), a Member who can really bring a very powerful personal experience to this issue.

□ 1000

Ms. GARCIA of Texas. Madam Speaker, I am here today to express my support for this very important piece of legislation. This is simple; it is much needed; and it is just a commonsense bill.

For my friends across the aisle who think that this is some intellectual exercise, that we are trying to find some mandate, or that we need to listen to the front lines, well, I am here to tell you what happens on the front lines.

It was not yesterday; it was when I was a geriatric social worker. We had

received a report of a street child taking care of a senior, and there was concern about the senior and the street child.

I went to the door to make an assessment. I knocked on the door, and I was greeted by a Saturday night special right in my face, as a social worker just trying to do my job. She kept saying: ''You ain't gonna take my baby. You ain't gonna take my baby.'' I was scared, scared, and scared, never having had a gun to my face.

Madam Speaker, I am sure you know what I am talking about because you have probably had similar experiences.

I was a social worker just trying to make an assessment to see if this senior needed help at home. I had nothing to do with trying to take her child away, but she confused me for a child welfare worker.

This is what can happen. It has happened to me. It happens today. As Representative STEVENS pointed out, it happened at 2 a.m. this morning, not to a social worker but to a FedEx worker. We must do something to make sure that we can protect workers and that we end workplace violence.

This is a small step. It is not an intellectual exercise. It is real. I am speaking personally, and I am here to stand with social workers across America to make sure that we do everything we can to make their workplace safe and that everyone is protected.

Ms. FOXX. Madam Speaker, I reserve the balance of my time.

Mr. COURTNEY. Madam Speaker, I yield 1 minute to the gentlewoman from Illinois (Ms. SCHAKOWSKY).

Ms. SCHAKOWSKY. Madam Speaker, workplace violence has reached epidemic levels and is the third greatest cause of job death right now.

Nurses, medical assistants, emergency responders, and social workers face some of the greatest threats, suffering more than 72 percent of all workplace assaults. Women suffer two out of every three serious workplace violence incidents.

This is unacceptable. We need to protect workers and require employers to put in place effective workplace violence prevention plans. It is simple. Make a plan.

We need to protect our healthcare and social service workers who have done so much for us during the pandemic to care for us. Now, we need to care for them.

We need H.R. 1195 now. Let's come together and get it done.

Madam Speaker, I include in the RECORD an editorial column from Bonnie Castillo and a letter from the AFL–CIO.

[From The Hill, Apr. 9, 2021]

WE CAN'T AFFORD TO LOSE ONE MORE NURSE—PASSING WORKPLACE VIOLENCE PREVENTION BILL WOULD HELP

(By Bonnie Castillo, Opinion Contributor)

''My children were very distraught to see their mom with a black eye,'' said Luciana Herr, a registered nurse in the inpatient psychiatry unit at Abbott Northwest Hospital in Minneapolis, Minn. Herr entered a hospital room in early March to find a patient hitting and biting her co-worker. With no security or other staff around, she tried to help and was punched in the face twice and kicked several times. It was the second time she had been assaulted in just a few months.

Tragically, Herr's story is all too common. According to the Bureau of Labor Statistics, health care and social service workers have a five times greater likelihood of experiencing a workplace violence-related injury than workers overall. This extremely high rate of violence is unacceptable, a fact driven home by the pandemic. We cannot let nurses and other health care workers go one more day fighting for optimal COVID protections while also wondering whether they will be assaulted at work.

That's why National Nurses United (NNU), the largest union of registered nurses in the United States, is fighting to get a critical bill across the finish line. The Workplace Violence Prevention for Health Care and Social Service Workers Act (H.R. 1195) would mandate that federal OSHA hold health care and social service employers accountable for developing and implementing a comprehensive workplace violence prevention plan, publicly reporting incidents of violence, and not retaliating against workers who report violence.

The legislation passed the U.S. House in the 116th Congress and was reintroduced this session by U.S. Rep. Joe Courtney (D–Conn.). It will come up for a floor vote soon in the House, and nurses across the country urge congressmembers to vote yes.

Planning to prevent violence means everything because once violence happens, it's already too late. This truth really hit home when our beloved NNU member Cynthia Palomata, a registered nurse in California, was killed by her patient in 2010. Countless nurses across the country are attacked physically and verbally each year, and the violence may be growing. A November 2020 National Nurses United survey of 15,000 registered nurses across the country found that 20 percent of respondents reported an increase in workplace violence during the pandemic.

It's important to remember that when nurses aren't safe, patients, visitors, and family members are also not safe. Violence can harm anyone in the vicinity.

According to Herr, staffing at an optimal level, adding security, and making sure patients are assessed and placed where they are best served are examples of actions her employer could take to curb violence before it happens. But there is no federal mandate for health care and social service employers to have a comprehensive, unit-specific prevention plan. This bill will establish one. In our profit-driven health care system, employers will never invest in prevention unless they are held accountable.

''All I got was an 'I am sorry that happened to you,' '' said Melanie Autrey, a general surgery registered nurse at Mission Hospital in Asheville, N.C., who—along with her co-worker—was attacked in January by a patient with dementia. ''It made me feel like I was not safe working here. It made me feel like 'What does it take?' ''

In Autrey's case, simple things may have helped, like the hospital investing in ''sitters,'' staff who can watch over patients in need of supervision and notice changes in behavior before a patient grows violent. There are so many clear actions that health care employers can take to prevent violence from happening and to ensure nurses can focus on caring for patients, not on wondering whether they will be hurt or killed on the job. But if we don't hold profit-driven employers accountable, they will never change.

As of early April, more than 3,570 registered nurses and other health care workers have already died of COVID–19. We can't afford to lose one more—not to the virus, not to violence, not to preventable causes. Congress must pass the Workplace Violence Prevention for Health Care and Social Service Workers Act without delay.

AFL–CIO,

Washington, DC, April 13, 2021.

DEAR REPRESENTATIVE: I am writing on behalf of the AFL–CIO to urge you to vote for the Workplace Violence Prevention for Health Care and Social Services Workers Act (H.R. 1195) when it is brought to the floor this week. This bill would direct the Occupational Safety and Health Administration (OSHA) to issue a federal workplace violence prevention standard to protect workers in health care and social services from injury and death. We also urge you to oppose Keller #6.

Workplace violence is a serious and growing safety and health problem that has reached epidemic levels. Workplace violence is the third leading cause of job death, and results in more than 30,000 serious lost-time injuries each year. Nurses, medical assistants, emergency responders and social workers face some of the greatest threats, suffering more than 72% of all workplace assaults. Women workers particularly are at risk, suffering two out of every three serious workplace violence injuries.

An OSHA standard under H.R. 1195 would protect these workers by requiring employers in the health care and social service sectors to develop and implement a workplace violence prevention plan, tailored to specific workplaces and worker populations. As part of the plan, employers would be required to work with employees to identify and correct hazards, develop systems for reporting threats of violence and injuries, provide training for workers and management and protect workers from retaliation for reporting workplace violence incidents. Common sense prevention measures include alarm devices, lighting, security, and surveillance and monitoring systems to reduce the risk of violent assaults and injuries.

The requirements for a workplace violence prevention plan are based upon existing recommendations from OSHA, NIOSH and professional associations, and scientific studies have found these guidelines to significantly reduce the incidence of workplace violence. Similar measures have been adopted in a number of states and implemented by some employers. Currently, however, there is no federal OSHA workplace standard, which would ensure these measures are in place. The majority of healthcare and social service workers lack effective protection and remain at serious risk while OSHA has been slow to act.

The AFL–CIO opposes Keller # 6, the Amendment in the Nature of a Substitute, as it will continue to delay protections for workers and will weaken the underlying protections of H.R. 1195. Working people need protection from workplace violence now, and should not have to wait seven years or more, the average time it takes for OSHA to issue a safety and health standard. It has been over four years since OSHA issued a Request for Information on workplace violence. Since this initial step, the agency has not taken additional action.

In recognition of the urgency to protect these workers from dangerous assaults, we support the underlying bill, which requires OSHA to develop an interim standard within one year and a final standard within 42 months. OSHA issued its first guidance to employers on protecting health care and social service workers from workplace violence

25 years ago in 1996. These frontline workers cannot wait any longer; their lives are in danger.

The underlying bill has broad support from health care professionals, safety and health professionals and healthcare unions including the National Association of Social Workers, American Public Health Association, American Industrial Hygiene Association and American Society of Safety Professionals. Also, this important legislation passed the House during the 116th Congress with 251 votes and continues to have strong bipartisan support.

We urge you to support H.R. 1195 to help protect health care and social service workers from the growing threat of workplace violence and unnecessary injury and death. We also urge you to oppose any Motion to Recommit, which would have the effect of killing the bill.

Sincerely,

WILLIAM SAMUEL,
Director, Government Affairs.

Ms. FOXX. Madam Speaker, may I inquire as to how much time is remaining.

The SPEAKER pro tempore. The gentlewoman from North Carolina has 11¾ minutes remaining. The gentleman from Connecticut has 11¼ minutes remaining.

Ms. FOXX. Madam Speaker, I reserve the balance of my time.

Mr. COURTNEY. Madam Speaker, I yield 1 minute to the gentlewoman from Minnesota (Ms. CRAIG).

Ms. CRAIG. Madam Speaker, just over 2 months ago, a man walked into an Allina Health clinic in Buffalo, Minnesota, and opened fire, killing one employee and injuring four others.

On that tragic day, nurses, doctors, social workers, and others were reportedly targeted because of their professions.

Tragically, this senseless and horrific act of violence is representative of a broader trend in our society. Today, members of the healthcare workforce are five times as likely to suffer a workplace injury than Americans in other professions.

Madam Speaker, what in the hell are we doing in Congress if we are not going to stand up and do anything for our healthcare heroes and those workers?

My colleagues who vote against this bill are ignoring the pleas of the EMTs, the emergency workers, and all of those folks who have been on the front lines of this healthcare pandemic.

The SPEAKER pro tempore. The time of the gentlewoman has expired.

Mr. COURTNEY. Madam Speaker, I yield an additional 15 seconds to the gentlewoman from Minnesota.

Ms. CRAIG. Madam Speaker, it is our responsibility to step forward and help protect our workers. It is beyond the pale to put our heads in the sand, as Members of Congress, and say there is nothing that we can do. What the hell are we doing here if we do that?

Ms. FOXX. Madam Speaker, I yield myself such time as I may consume.

Madam Speaker, we grieve for anyone who is killed violently in this country under any circumstances. Again, that is not a partisan issue.

Madam Speaker, the healthcare industry is currently in the midst of responding to a once-in-a-century pandemic and has rightly prioritized significant resources to caring for patients and keeping its employees safe from COVID–19.

Forcing OSHA to issue an interim final standard on workplace violence within 1 year, as H.R. 1195 requires, will have a devastating impact on the healthcare industry during the COVID–19 pandemic.

The last thing our healthcare providers need during this unprecedented public health crisis is more costly mandates from Washington that will strain resources and personnel and jeopardize patient care.

Moreover, the Biden administration is expected to soon impose new employer mandates in the form of an OSHA emergency temporary standard for COVID–19 and, eventually, a permanent infectious disease rule, which will have a significant impact on the healthcare industry.

At a time when healthcare facilities are experiencing massive revenue losses and have invested significant resources into responding to COVID–19, the issuance of two new regulations from Washington, potentially within months of each other, will be devastating.

Our Nation's healthcare providers have responded admirably to the pandemic and are doing heroic work to keep Americans safe and healthy. The House should reject this ill-timed and ill-advised legislation that will inhibit work and burden the healthcare industry at exactly the wrong time.

Madam Speaker, I reserve the balance of my time.

Mr. COURTNEY. Madam Speaker, I yield myself such time as I may consume.

Madam Speaker, just to clarify, the April 9 CBO report that came out, which, again, cited the numbers which were cited accurately by the opposition, is a number that is spread out over 200,000 facilities across the country.

If you do the math, we are talking about $9,000 per facility per year. Ask yourself whether or not that figure, weighing the balance of what we are trying to protect here, which is people's health and lives, is worth it.

I think most people would apply common sense to that and realize that it is not going to drive healthcare costs through the roof. In fact, it is going to protect workers and protect them from absenteeism. It is going to protect these institutions from high workers' compensation costs. It is just common sense.

Madam Speaker, I yield 2 minutes to the gentlewoman from Michigan (Ms. TLAIB).

Ms. TLAIB. Madam Speaker, everyone should feel safe at work, and they should be safe at work.

I want to give testimony about Kenya, who is a 49-year-old certified nursing assistant. I want to bring her words here in the Congress to understand what we are trying to do, who we are trying to protect.

She said: ''You don't know if you are going to take the virus home to your family or not. I have two children, 16 and 18, and a 1-year-old grandbaby that I worry about all the time.

''I have a designated place where I take my uniform off and my shoes off to keep my family safe. I come in, go directly to the basement, where I already have a change of clothes, strip all my clothes off, put all of my clothes directly into the washing machine.

''Then there is my mom. I am her only child now, so that is a big scare because who is going to take care of her?

''It is very scary for my family. They don't want me to go back to work. But I have to go to work because I have to be able to take care of my family, and I tell them that my residents need me.''

These are the human stories behind the fact that people right now are asking us, the United States Congress, to pass legislation that is long overdue to protect workers in some of the most high-stress, least-appreciated positions in our communities.

These workers are on the front lines, day in and day out, serving vulnerable groups and facing rates of workplace violence at five times the rate of workers in other communities.

She is expressing in here just the stress of it and, on top of that, workplace violence.

Madam Speaker, I include in the RECORD a letter of support from SEIU on behalf of the over 1 million healthcare and social service workers across our country.

SERVICE EMPLOYEES
INTERNATIONAL UNION,
Washington, DC, March 25, 2021.

DEAR REPRESENTATIVE: On behalf of the over 1 million healthcare and social services workers of the Service Employees International Union and the 80,000 nurses of the National Nurse Alliance of SEIU Healthcare whom have been on the frontlines of the COVID–19 pandemic, I urge you to support H.R. 1195, the Workplace Violence Prevention for Health Care and Social Service Workers Act.

Nurses are on the front lines of care, and workplace violence against healthcare workers, especially nurses, is an enormous and underreported problem. Almost three quarters of workplace violence injuries are suffered by healthcare and social service workers and these workers are nearly 5 times more likely to experience violence on the job than any other worker in the US. As nurses, we know that threats and violence are a major impediment to the essential care we provide.

H.R. 1195 would direct the Occupational Safety and Health Administration (OSHA) to issue a federal workplace violence standard. This specific standard would require employers in health care and social service assistance sectors to develop and implement a plan to protect workers from workplace violence.

The legislation requires that employer prevention plans be tailored to a specific workplace and employee population. This is important to overcome the very dangerous

myth that workplace violence is part of the job, essentially random or unpredictable, and therefore, not preventable. Workplace violence, in both health care and social service assistance settings, has clear patterns and identifiable risks. Research has found that evidence-based practices, when implemented consistently, can significantly reduce incidents of workplace violence.

We cannot expect nurses, who spend more time with patients than any other health care providers and have been at the forefront of providing care during the pandemic, to be able to deliver the high-quality care we were trained to provide under threat of violence and assault. A safe and violence-free workplace is essential to good patient outcomes and an exceptional healthcare system.

Essential workers have put their lives on the line throughout the pandemic and now elected leaders must meet their demands to be respected, protected and paid. We ask that you support H.R. 1195 and send a clear message that message that Congress will not ignore the harm and suffering caused to health care, behavioral health and social assistance workers by workplace violence.

Sincerely,

MARTHA BAKER, RN,
President SEIU 1991, Chair, National Nurse Alliance of SEIU Healthcare.

Ms. TLAIB. These are protections that should have long been in place and enforced. I urge my colleagues to support this legislation.

When passed and signed into law, I urge OSHA to immediately work to issue the standards necessary to protect these workers.

The SPEAKER pro tempore. The time of the gentlewoman has expired.

Mr. COURTNEY. Madam Speaker, I yield an additional 30 seconds to the gentlewoman from Michigan.

Ms. TLAIB. Madam Speaker, I gave that story of Kenya, who lives in Livonia, Michigan, because, on top of all of that, she was dealing with the number of protections that were lacking in the workplace.

Again, these are people who take care of our loved ones, take care of our sick, take care of those who are mentally ill, who need assistance, whose family members are not equipped for what they are trying to do. The least we can do, especially during this pandemic, is to offer them more protection and safety in the workplace.

Ms. FOXX. Madam Speaker, I yield myself the balance of my time.

Madam Speaker, overbearing regulations burden workers and stifle the economy. Preventing workplace violence in healthcare and social service settings is crucial, and we should get this done by allowing OSHA to issue standards through the normal rulemaking process, which brings all experts and parties, including small businesses, to the table.

Short-circuiting the process and rushing to a conclusion eliminates valuable technical and scientific input and will lead to unintended consequences, which could have a detrimental impact on workplace safety outcomes.

A bipartisan solution was possible here, but once again, Democrats have kicked it to the curb. I urge a ''no'' vote on H.R. 1195, and I yield back the balance of my time.

Mr. COURTNEY. Madam Speaker, I yield myself the balance of my time.

Here is the good news. When we started this journey on this legislation back in 2013, a number of us requested a GAO report because we had heard anecdotal evidence about the fact that healthcare workers were experiencing this really disturbing level of violence that was something that people had really never seen before.

GAO took 3 years, very methodically, as only they do. They are the gold standard, in terms of research. They brought in all the studies and all the evaluations. They verified, sadly, all the statistics that we have talked about here on the floor today. Seventy-three percent of incidents happen in these two sectors. The fact is that they not only verified that, but they showed that those numbers are actually underreported.

What is happening out there is because we don't have any system that people can turn to when they are experiencing this kind of unacceptable behavior. They basically are in a situation where, most of the time, they just are saying suck it up, shake it off, that is part of the job, just move on, don't spend any time on that.

In fact, what GAO told us is that the numbers that we are seeing in other sorts of reports underreport what is going on out there.

We took that report, and we crafted legislation. We really did accommodate some of the issues that we have heard talked about on the floor here today, about ensuring that there is going to be an adequate comment period for all stakeholders. We want that. We understand that the hospital association, just like the emergency room doctors, just like the nurses, should all have their opportunity to weigh in, in terms of what is a viable, workable standard.

□ 1015

But what we don't need is to have OSHA just sort of lapse into its notorious dysfunctional delays in terms of developing a workforce standard.

Mr. SCOTT ticked off, again, some of the most recent examples: 2017 beryllium took 18 years, silica dust took 17 years.

Again, when the last administration came to the committee, they said, ''We are going to start the process. We are going to begin a docket in terms of getting a rulemaking.''

And then the first scheduled date was delayed, and then the second scheduled date was delayed again, and on and on and on. Right now, today, as we stand here in this Chamber, there is nothing scheduled.

When you really boil it down, where I think the disagreement exists—and I am happy to acknowledge that, but I think it is a meaningful distinction—is that we are going to put this agency on the clock. We are telling them that, you know, you can follow the procedures, take the comment, but we are not going to sit back and allow this unacceptable trend to continue unaddressed.

That agency was created back in the Nixon administration to protect America's workers, and as the branch of government that created them, we want them to develop a standard in a reasonable amount of time.

Madam Speaker, this is not unprecedented. Congresses, in the past, have done this. During the last pandemic, during AIDS, we saw a blood-borne pathogen that was just totally sweeping hospitals and healthcare institutions all across the country, and we intervened and put a clock on OSHA to develop a blood-borne pathogen workforce standard.

That is why, today, when you go to the hospitals, people are wearing gloves and using disposable needles. All that stuff that we take for granted now, that was OSHA. Actually, it was Congress who told OSHA to develop that standard. So we are in a situation here today in 2021 where, again, we are seeing something out there.

I thank Ms. FOXX because she is not in denial, that is for sure. She really thoughtfully talked about what is driving some of this, but the fact is now it is time to act. I thank some of the Republican Members who came forward because it is hard right now, but they came forward and cosponsored this bill.

I hope, Madam Speaker, that the shared experience of the last year that this country went through is something people will think about when they vote later today and support this legislation.

Madam Speaker, I yield back the balance of my time.

Ms. JACKSON LEE. Madam Speaker, as senior member of the Committees on the Judiciary, on Homeland Security, and on the Budget, I rise in strong support of H.R. 1195, the "Workplace Violence Prevention for Health Care and Social Service Workers Act," which would establish within one year an Occupational Safety and Health Administration ("OSHA") interim workplace standard requiring health care and social service providers to implement workplace violence prevention plans, and which would establish a permanent OSHA standard within 42 months.

Currently, there is no OSHA standard that requires employers to implement violence prevention plans that would help reduce workplace violence injuries among health care and social service workers.

The lack of an enforceable standard means that OSHA, the federal agency created to protect workers' safety, has few meaningful tools to protect health care workers from the threat of workplace violence.

The Government Accountability Office has estimated, conservatively, that it takes OSHA at least 7 years to issue a standard.

Seven years; Our healthcare workers have worked too hard and sacrificed too much for them to wait a minimum of seven more years before measures are in place to secure their basic physical safety.

H.R. 1195 would provide health and social service workers the protection they deserve by:

Compelling OSHA to issue an interim final standard in one year and a final standard within 42 months requiring employers within the health care and social service sectors to develop and implement a workplace violence prevention plan.

Identifying risks, specify solutions, and require training, reporting, and incident investigations. It would also provide protections from retaliation for reporting violent incidents.

Protecting health care and social service workers in the public sector in the 24 states not covered by OSHA protections.

Our nation's caregivers—including nurses, social workers, and many others who dedicate their lives to caring for those in need—suffer workplace violence injuries at far higher rates than any other profession.

While the previous administration relegated the OSHA standard protecting healthcare and social workers to the back burner, making no progress for 4 years, we will not do the same.

Study after study has confirmed that healthcare workers are not adequately protected in the workplace.

In 2014, OSHA reported that there are nearly as many serious violent injuries in healthcare as there are in all other industries combined.

In 2018, the U.S. Bureau of Labor Statistics (BLS) reported that the rate of violence against health care workers increased more than 60 percent between 2011 and 2018.

Just last year, the BLS reported that health care and social service workers were nearly five times as likely to suffer a serious workplace violence injury than workers in other sectors.

And this problem has been exacerbated by the influx of patients and stressors during the COVID–19 pandemic—according to National Nurses United, 20 percent of registered nurses across the U.S. reported increased workplace violence due to the pandemic.

This is not a new problem; this is an old problem that has found fertile ground to grow during the COVID–19 pandemic due to an influx of patients and increasing demands on our healthcare workers.

In my home state of Texas, over 50 percent of nurses in Texas have reported being subject to workplace violence during the course of their career.

A 2016 study by the Texas State Health Services found that in any given year:

6 percent of Texas nurses experience sexual harassment;

12 percent of Texas nurses experience physical violence;

Nearly half of all Texas nurses experience verbal abuse.

The injuries healthcare workers take from workplace violence are not only physical; victims of workplace violence often suffer mental trauma that they will carry with them for the rest of their lives.

One example is Bridgette Jenkins, a nurse for 20 years in Houston and professor at Houston Baptist University's School of Nursing, who will not work in a psychiatric ward because 19 years ago a psychiatric patient hit her so hard that half her face became swollen and doctors encouraged her to get an x-ray to ensure her jaw wasn't broken.

Another is Norma Broadhurst, who testified before the Texas House of Representatives that she experienced a ''traumatic amputation'' of her right ring finger due to an intoxicated spring break patient biting off her finger.

Workplace violence against healthcare workers is so ubiquitous that more than a third of Texas nurses surveyed who did not report a recent violent incident said they did so because it was ''an accepted/expected part of the job'' or because they did ''not expect anything to change.''

One stark example of this is Kimberly Curtin, a nurse for nearly 28 years in Houston, who was punched in the side of the head by a patient as a young nurse.

Her colleague who witnessed the attack said to her, ''Welcome to ER.''

As of 2019, according to the Texas Health and Human Services Commission, Harris County has 4,303 registered physicians and 45,946 registered nurses.

That is over 50,000 individuals in my district that have been on the front lines of the fight against the pandemic, where in addition to facing a historically deadly virus they have been spit on, cursed out, sexually harassed, and physically assaulted.

I cannot stand by while knowing that these people I represent, who give so much to others, who have a personal and professional obligation to ''do no harm,'' and who have a steadfast focus on helping patients, must remain constantly vigilant at their place of work due to potential threats to their physical safety.

Madam Speaker, throughout this deadly COVID–19 pandemic, we have called our healthcare workers heroes, and we have lauded them for being the front line defense against this deadly violence.

But words are only the first step towards action, and action is what is needed here today.

Although it is not enough, the very least we can do to repay their sacrifice and heroism is make sure healthcare workers everywhere are secure against violence from within their workplace.

I urge all members to join me in voting to pass H.R. 1195, the ''Workplace Violence Prevention for Health Care and Social Service Workers Act,'' to reduce workplace violence injuries among health care and social service workers.

[The Texas Tribune, Feb. 9, 2021]

HALF OF TEXAS' NURSES EXPERIENCE WORKPLACE VIOLENCE. A TEXAS LAWMAKER SAYS IT'S TIME TO PROTECT THEM.

(By Shannon Najmabadi and Neelam Bohra)

Steven D. Powell is a nurse with Texas Medical Center in Houston. Powell said violent patients have left him covered in bruises, but he more regularly faces verbal assaults. Credit: Shelby Tauber for The Texas Tribune

State Rep. Donna Howard was working as an intensive care unit nurse in the 1970s when a patient pulled an intravenous drip out of his arm and walked toward her. She rushed to help him—but didn't see the metal urinal he was clutching behind his back until it was too late. He smacked her in the jaw with it, knocking her across the room. ''I was briefly stunned by the hit,'' said Howard, then working at the Brackenridge hospital in Austin. ''But I continued working.''

For decades, health care workers have faced rampant violence in the workplace. Now praised as heroes of the pandemic, those front-line medical workers have been routinely scratched, bitten or verbally abused by patients. Well over half of Texas' nurses reported being subject to workplace violence in their career, according to a 2016 state study.

Nationwide, the rate of violence for health care workers increased more than 60% between 2011 and 2018, and the Occupational Safety and Health Administration has found the rate of serious violent incidents in health care is more than four times greater than for those in other industries.

''It is presumed to be a part of the job,'' Howard, D-Austin, said of the violence. ''That's not OK.''

There are no federal laws that specifically target violence in nurses' workplaces. OSHA does not require health care facilities to have violence prevention plans, though states like California and Washington have passed laws to do so. Howard has filed similar legislation in Texas that if passed this year, would place Texas in a vanguard of states that have backed similar protections for nurses.

It would require health care providers to create committees to prevent workplace violence and to offer medical treatment and other services after a violent incident. It would also bar facilities from penalizing nurses who report abuse.

''They are there to take care of us. And I think we have a responsibility to take care of them,'' Howard said, adding that this year especially, lawmakers have a moral obligation to take care of health care workers who have been risking their lives throughout the pandemic.

State lawmakers have for years heard examples of the violence nurses face.

Rep. Stephanie Klick, R–Fort Worth, who has worked as a nurse, said in a committee hearing that her wrist was broken by an elderly patient and that she had to have surgery to repair it.

Cindy Zolnierek, head of the Texas Nurses Association, said a patient tried to punch her in the face on her first day as a graduate nurse. She quickly stepped back to avoid being struck.

And in 2013, an emergency room nurse named Norma Broadhurst told a panel of lawmakers she'd had a ''traumatic amputation'' of her right ring finger after it was bitten off by an ''intoxicated spring break patient'' who she was trying to help.

''I will never have my finger back to wear the ring my grandmother gave me,'' she said. ''Is this going to interfere with my wanting to help the next patient? . . . I am right-handed, everything I do involves this hand.''

That year, the Legislature strengthened the penalties for assaulting emergency room workers, putting the offense on par with harming first responders. Lawmakers later signed off on creating a grant program to find creative ways to lower the number of verbal and physical attacks against nurses. Those efforts have been focused on training, trying to quickly identify patients at high risk of lashing out, or raising public awareness about the rate of violence, Zolnierek said.

Nurse advocates say that a proactive approach is essential to stop assaults before they happen and leave health care workers and patients traumatized by the experience.

''Many members of the general public, they're like, 'Are you kidding me? People assault nurses?' They don't understand that it's a problem,'' Zolnierek said.

In Texas, more than a third of nurses surveyed for a 2016 report who did not report a recent violent incident said it was because it was ''anaccepted/ expected part of the job'' or because they did ''not expect anything to change.'' About a quarter of nurses—and nearly a third of those in freestanding emergency centers—said their employer was not at all or only ''slightly effective'' at managing workplace violence.

It's not just nurses. Respiratory therapists, dietary aides and other health care workers all face violence. Nearly half of emergency physicians have reported being physically assaulted at work.

Dr. Theresa Tran, an assistant professor of emergency medicine at the Baylor College of Medicine, said violence is an ''unfortunate commonality'' in emergency rooms everywhere and something workers there have to always be ''vigilant'' about.

An OSHA webpage says people who work in hospitals, nursing homes and other health care facilities face ''significant risks'' of violence, in part because they may work closely with people who have a history of violence or are under the influence of drugs. A state report said nurses have the ''highest risk'' among health professionals because of how often they interact with patients.

Zolnierek said nurses may be viewed as ''non threatening'' and may be vulnerable to being struck because they work in close proximity to patients. There can also be outdated sex-based stereotypes of nurses—about 88% of whom are women—as being passive or doctors' ''handmaids,'' said Zolnierek, though both male and female nurses experience sexual harassment from patients.

Daniel Funtong, a nurse who works in North Texas, said older patients sometimes react poorly to pain medication, in some cases threatening nurses with knives or spoons that are served with meals.

''I don't think they understand the magnitude, because after going through . . . trauma or injury and then the recovery process, and sometimes that brain doesn't function as normal,'' Funtong said.

A variety of factors can spark aggression or a violent outburst from patients. The presence of needles can trigger violence, and patients who want to leave the hospital or who are frustrated with waiting could be more prone to erupt, according to researchers who analyzed a year of incident reports at a hospital system in the midwest.

In other cases, patients' family members have lashed out if they think the health care worker isn't doing enough to care for their loved one.

Nurses and physicians ''constantly'' feel threatened by patients and family members, Funtong said, and have been trained to identify crisis-type situations and alert building security if needed. He wishes police would work closely with health care facilities' private security to more promptly intervene with violent patients.

Registered nurse Steven Powell said violent patients have left him covered in bruises, but he more regularly faces verbal assaults. Recently, a patient called him a racial slur—an occurrence that's not uncommon for nurses, according to experts.

''When you look at the workforce for nurses, it's a very diverse landscape,'' he said. ''The violence that they can experience from a verbal nature, threats due to their culture—they may keep it to themselves or not respond in the same manner that everyone would, having a plan like this that encourages reporting.''

Powell, who also works as a traveling nurse, said health care facilities he worked at in the Houston and Dallas areas were unprepared for the pandemic—and that lack of readiness extends to how they plan for violence.

''Not all facilities are taking the steps necessary to protect their staff,'' Powell said.

Some 82% of Texas nurses report being verbally abused, which can include yelling, swearing and the use of hurtful words, according to the 2016 state report. Nearly half also reported physical violence like being hit, slapped or choked.

The threat of violence or abuse can take a heavy toll, leaving health care workers with injuries, psychological trauma or decreased morale. Nurseswho face violence may trust their employers or coworkers less, become more guarded when treating patients or even leave the profession—while Texas faces a shortage of nurses.

''One abusive patient can negate 25 lovely patients, and it just hurts you on so many levels, more than just the physical,'' said Mary Ball, a registered nurse at Parkland Health & Hospital System. Ball said a coworker was recently bitten by a patient who drew blood, and that the hospital doesn't provide enough information to staff or the public about safety issues.

Ball, who is still in therapy after being robbed at gunpoint in an employee parking lot almost two years ago, said she wishes more armed officers were present in and outside the hospital and said that restraints should be more frequently used to protect them from potentially violent patients.

A Parkland spokesperson said the hospital ''puts out a great deal of information about safety and discusses these matters regularly in our system-wide town halls, which is open to all employees.'' Police officers are also present to protect patients and employees.

The Dallas-based hospital has used other initiatives to try to reduce workplace violence. It created a free course a few years ago to raise awareness about the prevalence of workplace violence and to teach employees and nursing students how to protect themselves. It also purchased wearable alarm systems for employees that can emit a piercing noise if they need help and are not near a panic button, said Karen Garvey, Parkland's vice president of safety and clinical risk management.

Ball said the wearable alarm wouldn't have helped her when she was being robbed.

Workplace violence is thought to be vastly underreported among health care workers, in part because of a professional obligation to ''do no harm,'' and a steadfast focus on helping patients, even those who hurt them, according to experts. Some health care workers who experience violence may not want to blame or shame violent patients who are ill or affected by medication. Others may be reluctant to report violence because they view it as part of their job, fear retaliation from their employer or are deterred by the time and administrative hassle of going through the process, experts say.

They may think, '''Nothing ever happens when I report so why should I bother?''' said Judy Arnetz, a professor at Michigan State University who for decades has studied workplace violence in the health care sector. Some health care workers may also sympathize with the patient and think they ''didn't mean to hurt me, that patient . . . suffers from dementia or was under the influence,'' she said.

Though awareness about workplace violence has grown, there's still a dearth of information about how frequently it erupts and affects health care workers, largely because of a lack of reporting, said Arnetz, one of the researchers who analyzed incidents at the Midwestern hospital system.

Health care workers and experts have said hospitals can add more security guards or metal detectors and instill a culture of violence prevention to help deter workplace violence. They should also better understand where violence is occurring and why. Violent outbursts have been reported more frequently in emergency rooms or psychiatric facilities, where people may be anxious, stressed, in pain or under other kinds of psychological strain, experts have said. But it can still happen in other health care settings, and workers there may be less prepared to deal with the violence.

Tran, the emergency room physician, said health care workers' role in stabilizing patients and trying to find physical or mental issues that they cari address can add a complicated layer to the violence.

''I think health care workers, especially physicians and nurses in the ER, tolerate violence more than other industries because we see ourselves in a position where we're supposed to help patients and look past any aggressions on ourselves,'' she said.

The SPEAKER pro tempore. All time for debate has expired.

Each further amendment printed in part C of House Report 117–15 not earlier considered as part of amendments en bloc pursuant to section 6 of House Resolution 303, shall be considered only in the order printed in the report, may be offered only by a Member designated in the report, shall be considered as read, shall be debatable for the time specified in the report equally divided and controlled by the proponent and an opponent, may be withdrawn by the proponent at any time before the question is put thereon, shall not be subject to amendment, and shall not be subject to a demand for division of the question.

It shall be in order at any time for the chair of the Committee on Education and Labor or his designee to offer amendments en bloc consisting of further amendments printed in part C of House Report 117–15 not earlier disposed of. Amendments en bloc shall be considered as read, shall be debatable for 20 minutes equally divided and controlled by the chair and ranking minority member of the Committee on Education and Labor or their respective designees, shall not be subject to amendment, and shall not be subject to a demand for division of the question.

AMENDMENTS EN BLOC OFFERED BY MR. COURTNEY OF CONNECTICUT

Mr. COURTNEY. Madam Speaker, as the designee of the chairman of the Education and Labor Committee, and pursuant to section 6 of House Resolution 303, I rise to offer amendments en bloc.

The SPEAKER pro tempore. The Clerk will designate the amendments en bloc.

Amendments en bloc consisting of amendment Nos. 1, 2, 3, 4, and 6, printed in part C of House Report 117–15, offered by Mr. COURTNEY of Connecticut:

AMENDMENT NO. 1 OFFERED BY MR. BROWN OF MARYLAND

On page 17, after line 21, insert the following:

(D) Additional training shall be provided for each such covered employee whose job circumstances require working with victims of torture, trafficking, or domestic violence.

Beginning on page 17, line 22, and ending on page 18, line 13, redesignate subparagraphs (D) through (G) as subparagraphs (E) through (H).

AMENDMENT NO. 2 OFFERED BY MR. COHEN OF TENNESSEE

Page 8, line 3, strike ''and'' and insert ''Alzheimer's and memory care facility, and''

AMENDMENT NO. 3 OFFERED BY MR. DELGADO OF NEW YORK

Page 4, line 6, strike ''and''.

Page 4, line 12, strike the period and insert ''; and''.

Page 4, after line 12, insert the following:

(C) that provides for a period determined appropriate by the Secretary, not to exceed 1 year, during which the Secretary shall

prioritize technical assistance and advice consistent with section 21(d) of the Occupational Safety and Health Act of 1970 (29 U.S.C. 670(d)) to employers subject to the standard with respect to compliance with the standard.

AMENDMENT NO. 4 OFFERED BY MR. JONES OF NEW YORK

Page 11, line 18, strike ''shall''.
Page 11, line 19, insert ''shall'' before ''be''.
Page 11, line 23, insert ''shall'' before ''be''.
Page 12, line 2, strike ''and'' at the end.
Page 12, line 3, insert ''shall'' before ''be''.
Page 12, line 6, strike the period at the end and insert ''; and''.
Page 12, after line 6, insert the following:
(iv) may be in consultation with stakeholders or experts who specialize in workplace violence prevention, emergency response, or other related areas of expertise for all relevant aspects of the Plan.

AMENDMENT NO. 6 OFFERED BY MS. OCASIO-CORTEZ OF NEW YORK

Page 26, line 25, strike ''and''.
Page 27, line 4, strike the period and insert ''; and''.
Page 27, after line 4, insert the following:
(4) nothing in this Act shall be construed to limit or diminish any protections in relevant Federal, State, or local law related to—
(A) domestic violence;
(B) stalking;
(C) dating violence; and
(D) sexual assault.

The SPEAKER pro tempore. Pursuant to House Resolution 303, the gentleman from Connecticut (Mr. COURTNEY) and the gentlewoman from North Carolina (Ms. FOXX) each will control 10 minutes.

The Chair recognizes the gentleman from Connecticut.

Mr. COURTNEY. Madam Speaker, I yield myself such time as I may consume.

Madam Speaker, I rise in support of the amendments en bloc.

These five amendments will: one, direct OSHA to prioritize providing technical assistance and advice to employers to promote compliance during the first year; two, clarify that nothing in this act will limit existing protections against domestic violence, stalking, or sexual violence; three, clarify that employers can consult experts when developing their workplace violence prevention plans; four, provide additional training to workers who interact with survivors of torture, trafficking, and domestic violence; and, five, adds Alzheimer's and memory care facilities as facilities covered by this legislation.

These amendments make meaningful improvements to the bill, and I urge a ''yes'' vote on the amendments en bloc.

Madam Speaker, I yield 1 minute to the gentleman from New York (Mr. JONES).

Mr. JONES. Madam Speaker, my amendment makes a simple change that would help improve the development of workplace violence prevention plans required under H.R. 1195, the Workplace Violence Prevention for Health Care and Social Service Workers Act.

As you know, our Nation's nurses, social workers, and other caregivers suffer from workplace violence injuries at far higher rates than any other profession. In fact, these workers are nearly five times as likely to suffer a serious workplace violence injury than workers in other sectors, according to the Bureau of Labor Statistics.

The underlying legislation would require employers within these sectors to develop and implement a workplace violence prevention plan to reduce the incidence of injuries and create safer working conditions for their workers.

In order to ensure that covered employers in the healthcare and social service industries develop thoughtful and comprehensive workplace violence prevention plans, my amendment clarifies that employers are able to outreach to experts and specialists who lead in the issue of workplace violence.

Healthcare and social service workers have unique needs and face many difficult challenges in the workplace.

The SPEAKER pro tempore. The time of the gentleman has expired.

Mr. COURTNEY. Madam Speaker, I yield an additional 15 seconds to the gentleman from New York.

Mr. JONES. Madam Speaker, I include in the RECORD a letter of support for H.R. 1195 from the CEO of AIHA, Mr. Sloan.

AIHA.

SUPPORT FOR H.R. 1195, WORKPLACE VIOLENCE PREVENTION FOR HEALTH CARE AND SOCIAL SERVICE WORKERS ACT

Rep. ROBERT C. ''BOBBY'' SCOTT,
Chair, Education and Labor Committee, House of Representatives.
Rep. VIRGINIA FOXX,
Ranking Member, Education and Labor Committee, House of Representatives.

DEAR CHAIRMAN SCOTT, RANKING MEMBER FOXX, AND MEMBERS OF THE COMMITTEE: On behalf of AIHA, which represents scientists and professionals committed to preserving and ensuring occupational and environmental health and safety in the workplace and community, I urge you to quickly approve H.R. 1195, the Workplace Violence Prevention for Health Care and Social Service Workers Act.

AIHA supports this bipartisan bill, which has 120 cosponsors and would address workplace violence in health care and social service settings. Violence in these industries remains a leading cause of traumatic workplace injury and death in the US. The bill would help solve this problem by requiring covered employers to develop and implement comprehensive workplace violence prevention plans that are tailored to meet their individual needs.

AIHA looks forward to our continued work together on workplace violence and other occupational and environmental health and safety issues.

Sincerely,
LAWRENCE D. SLOAN,
Chief Executive Officer, AIHA.

Ms. FOXX. Madam Speaker, I yield myself such time as I may consume.

We all agree American workers should be kept out of harm's way on the job so they can safely and healthily return home to their families. These caregivers deserve protections, but H.R. 1195 is the wrong approach to address the important issue of workplace violence.

I am disappointed by the lack of effort to develop a workable bipartisan solution to combat workplace violence before this flawed legislation was rushed to the floor by Democrat leaders in Congress.

In fact, committee Democrats chose not to hold a legislative hearing focused on this bill. Unfortunately, the Democrat amendments only reinforce that H.R. 1195 is the wrong approach to addressing this important issue.

Representative BROWN's amendment, while well-intentioned, ignores the fact that there are Federal agencies other than OSHA that would be better equipped to handle a regulatory requirement for the education of healthcare and social service workers who work with the victims of torture, trafficking, or domestic violence.

The question of whether employer education programs governed by OSHA, the Federal Government's workplace safety agency, are appropriate to address the objectives of this amendment should be thoroughly vetted and discussed during the rulemaking process before decisions impacting healthcare facilities and their patients are made. H.R. 1195 does not allow for this to occur.

Representative COHEN's amendment is also well-intentioned, but will unilaterally expand the reach of a flawed regulation to include numerous small facilities.

This is particularly problematic because H.R. 1195 precludes the opportunity for OSHA to conduct a Small Business Regulatory Enforcement and Fairness Act panel prior to a regulation being written, a key element in the process which considers the impact of proposed regulatory changes on small businesses. The implications of such a proposal should be carefully evaluated through the established OSHA rulemaking process before a decision is made regarding expansion to additional facilities.

With regard to Representative DELGADO's amendment, I agree with his assessment that employers will need compliance assistance and technical help from OSHA in order to understand the complex and burdensome new rule mandated by this bill.

However, this amendment is little more than window dressing. While technical assistance is always welcome and appropriate for a rule of this complexity, this amendment places an arbitrary time limit that is woefully insufficient to cope with a rushed and flawed rule. Moreover, technical assistance after employers are subject to a rule in which they had no input is too little, too late.

Rather than amend a flawed bill by allowing the Department of Labor to help businesses after the fact, we should reject this bill and instead allow OSHA to pursue its established rulemaking process that provides ample opportunity for feedback from stakeholders and the public, which will ensure a better product and eliminate the need for this type of amendment.

Representative JONES' amendment puts the cart before the horse. Consultation with outside experts regarding compliance should occur while a regulation is being written by OSHA and before it is issued so the final product takes this expertise into account. This amendment simply adds yet another costly mandate on employers.

H.R. 1195, which requires OSHA to issue an interim final rule within 1 year, short-circuits the opportunity for the agency to hear from experts before a rushed rule is issued. This amendment is a feeble attempt to correct this critical flaw.

I believe, Madam Speaker, that every Member of this Chamber is committed to ensuring American workers are safe in the workplace. I appreciate Mr. COURTNEY's very kind comments about my concern for this personally, but I can say every Republican feels this way.

Our Nation's caregivers, who have been on the front lines of responding to the COVID–19 pandemic, are deserving of a responsible, workable, and thorough response to the serious issue of violence in the workplace. However, this legislation is a far cry from a sensible or workable solution.

H.R. 1195 is overly prescriptive and heavy-handed and takes the wrong approach, prejudging and imposing a rushed regulation without allowing for necessary stakeholder input. Unfortunately, the Democrat amendments do nothing to change this fact.

Madam Speaker, I urge my colleagues to oppose the Democrat amendments en bloc and the underlying bill, and I reserve the balance of my time.

Mr. COURTNEY. Madam Speaker, I yield 2½ minutes to the gentleman from Tennessee (Mr. COHEN).

Mr. COHEN. Madam Speaker, I appreciate Mr. COURTNEY for yielding to me, and I appreciate him for bringing this bill. He has a long history of now 15 years of looking out for workers, laborers, and their fair place in our country, and I thank him for that.

Over the past 13 months, our healthcare and social service workers have gone over and beyond in their efforts to keep us healthy and free during this COVID–19 pandemic. This bill, the Workplace Violence Prevention for Health Care and Social Service Workers Act, is one way Congress can help keep them healthy and look out for their safety.

This amendment is a simple one. It simply says that Alzheimer's and memory care facilities are added to the type of residential treatment facilities covered by this bill. Alzheimer's and memory care facilities are sometimes overlooked in the definition and should not be.

With our aging population, Alzheimer's and dementia is growing in prevalence. In the United States, more than 5.5 million people now are living with Alzheimer's. The number is expected to increase to 14 million people by 2060. Alzheimer's is the sixth leading cause of death in our country, but third among senior citizens, behind only cancer and heart disease. This increase in Alzheimer's diagnoses means more healthcare workers and social workers will be needed to help patients and their families to try to manage this disease and cope with the effects.

This bill doesn't only help the workers, but it helps the victims of these diseases that put them in the institutions by making it more likely that people will want to go into those professions and not fear for their health.

As anyone who has or had a loved one with Alzheimer's knows that Alzheimer's patients can become aggressive for many reasons. Sometimes it is just the inability to grasp a subject or to remember something or they are hungry or whatever, and they get violent.

□ 1030

That is the reason oftentimes they are put into long-term facilities caring for Alzheimer's patients, and that is going to continue to grow. They have these outbursts of aggression. Healthcare professionals and social service workers need to be protected similar to their colleagues that work in residential treatment facilities.

I appreciate your consideration. I appreciate this amendment being put in the en bloc. Hopefully, we pass it and pass the bill and we look out for healthcare workers and the people who are the beneficiaries of their work. And they will need more and more service providers as the years go on.

Ms. FOXX. Madam Speaker, I believe I have the right to close, and I apologize for neglecting to say I oppose the amendment at the beginning.

I believe I have the right to close, therefore, I will reserve the balance of my time.

Mr. COURTNEY. Madam Speaker, again, I support the en bloc as stated earlier, and I yield back the balance of my time.

Ms. FOXX. Madam Speaker, again, I want to thank Mr. COURTNEY for the comments he has made during this debate today. He has been a very kind colleague.

However, what we should be doing is more debating of some of the underlying issues that are creating this increased workplace violence, and we are not doing that as a Congress.

We need to be looking at why these things that are happening are happening. And I am sorry that we are not doing that. And I am sorry we are doing a rushed product here when we could be working together.

Madam Speaker, I urge my colleagues to vote ''no'' on the en bloc amendments and ''no'' on the underlying bill, and I yield back the balance of my time.

The SPEAKER pro tempore. Pursuant to House Resolution 303, the previous question is ordered on the amendments en bloc printed in part C of House Report 117–15 offered by the gentleman from Connecticut (Mr. COURTNEY).

The question is on the amendments en bloc.

The en bloc amendments were agreed to.

A motion to reconsider was laid on the table.

AMENDMENT NO. 5 OFFERED BY MR. KELLER

The SPEAKER pro tempore. It is now in order to consider amendment No. 5 printed in part C of House Report 117–15.

Mr. KELLER. Madam Speaker, I have an amendment at the desk.

The SPEAKER pro tempore. The Clerk will designate the amendment.

The text of the amendment is as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Workplace Violence Prevention for Health Care and Social Service Workers Act''.

SEC. 2. TABLE OF CONTENTS.

The table of contents for this Act is as follows:

TITLE I—WORKPLACE VIOLENCE PREVENTION STANDARD

SEC. 101. FINAL STANDARD.

(a) IN GENERAL.—The Secretary of Labor shall promulgate a final standard on workplace violence prevention—

(1) to require certain employers in the healthcare and social service sectors, and certain employers in sectors that conduct activities similar to the activities in the healthcare and social service sectors, to develop and implement a comprehensive workplace violence prevention plan to protect health care workers, social service workers, and other personnel from workplace violence; and

(2) that may be based on the Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers published by the Occupational Safety and Health Administration of the Department of Labor in 2015 and adhere to the requirements of this title.

(b) EFFECTIVE DATE OF STANDARD.—The final standard shall—

(1) take effect on a date that is not later than 60 days after promulgation, except that such final standard may include a reasonable phase-in period for the implementation of required engineering controls that take effect after such date; and

(2) be enforced in the same manner and to the same extent as any standard promulgated under section 6(b) of the Occupational Safety and Health Act of 1970 (29 U.S.C. 655(b)).

(c) EDUCATIONAL OUTREACH.—

(1) DURING RULEMAKING.—During the period beginning on the date the Secretary commences rulemaking under this section and

ending on the effective date of the final standard promulgated under this section, the Secretary of Labor shall engage in an educational campaign for covered employees and covered employers regarding workplace violence prevention in health care and social service industries on the materials of the Occupational Safety and Health Administration on workplace violence prevention for such industries.

(2) REQUIREMENTS OF FINAL STANDARD.—Beginning on the date on which the final standard is promulgated under this section, the Secretary shall engage in an educational campaign for covered employees and covered employers on the requirements of such final standard.

SEC. 102. SCOPE AND APPLICATION.

In this title:

(1) COVERED FACILITY.—

(A) IN GENERAL.—The term ''covered facility'' means a facility with respect to which the Secretary determines that requirements of the final standard promulgated under section 101(a) would be reasonably necessary or appropriate, and which may include the following:

(i) Any hospital, including any specialty hospital.

(ii) Any residential treatment facility, including any nursing home, skilled nursing facility, hospice facility, and long-term care facility.

(iii) Any medical treatment or social service setting or clinic at a correctional or detention facility.

(iv) Any community-based residential facility, group home, and mental health clinic.

(v) Any psychiatric treatment facility.

(vi) Any drug abuse or substance use disorder treatment center.

(vii) Any independent freestanding emergency centers.

(viii) Any facility described in subparagraphs (A) through (G) operated by a Federal Government agency and required to comply with occupational safety and health standards pursuant to section 1960 of title 29, Code of Federal Regulations (as such section is in effect on the date of enactment of this Act).

(B) EXCLUSION.—The term ''covered facility'' does not include an office of a physician, dentist, podiatrist, or any other health practitioner that is not physically located within a covered facility described in subparagraphs (A) through (H) of paragraph (1).

(2) COVERED SERVICES.—The term ''covered service''—

(A) includes—

(i) any services and operations provided in home health care, home-based hospice, and home-based social work;

(ii) any emergency medical services and transport, including such services when provided by firefighters and emergency responders;

(iii) any services described in clauses (i) and (ii) performed by a Federal Government agency and required to comply with occupational safety and health standards pursuant to section 1960 of title 29, Code of Federal Regulations (as such section is in effect on the date of enactment of this Act); and

(iv) any other services and operations the Secretary determines should be covered under the standards promulgated under section 101; and

(B) does not include child day care services.

(3) COVERED EMPLOYER.—

(A) IN GENERAL.—The term ''covered employer'' includes a person (including a contractor, subcontractor, or a temporary service firm) that employs an individual to work at a covered facility or to perform covered services.

(B) EXCLUSION.—The term ''covered employer'' does not include an individual who privately employs a person to perform covered services for the individual or a friend or family member of the individual.

(4) COVERED EMPLOYEE.—The term ''covered employee'' includes an individual employed by a covered employer to work at a covered facility or to perform covered services.

SEC. 103. REQUIREMENTS FOR WORKPLACE VIOLENCE PREVENTION STANDARD.

Each standard described in section 101 may include the following requirements:

(1) WORKPLACE VIOLENCE PREVENTION PLAN.—Not later than 6 months after the date of promulgation of the final standard under section 101(a), a covered employer shall develop, implement, and maintain a written workplace violence prevention plan for covered employees at each covered facility and for covered employees performing a covered service on behalf of such employer, which meets the following:

(A) PLAN DEVELOPMENT.—Each Plan shall—

(i) subject to subparagraph (D), be developed and implemented with the meaningful participation of direct care employees and, where applicable, employee representatives, for all aspects of the Plan;

(ii) be applicable to conditions and hazards for the covered facility or the covered service, including patient-specific risk factors and risk factors specific to each work area or unit; and

(iii) be suitable for the size, complexity, and type of operations at the covered facility or for the covered service, and remain in effect at all times.

(B) PLAN CONTENT.—Each Plan shall include procedures and methods for the following:

(i) Identification of each individual or the job title of each individual responsible for implementation of the Plan.

(ii) With respect to each work area and unit at the covered facility or while covered employees are performing the covered service, risk assessment and identification of workplace violence risks and hazards to employees exposed to such risks and hazards (including environmental risk factors and patient-specific risk factors), which may be—

(I) informed by past violent incidents specific to such covered facility or such covered service; and

(II) conducted with—

(aa) representative direct care employees;

(bb) where applicable, the representatives of such employees; and

(cc) the employer.

(iii) Hazard prevention, engineering controls, or work practice controls to correct, in a timely manner, hazards that the employer creates or controls which—

(I) may include security and alarm systems, adequate exit routes, monitoring systems, barrier protection, established areas for patients and clients, lighting, entry procedures, staffing and working in teams, and systems to identify and flag clients with a history of violence; and

(II) shall ensure that employers correct, in a timely manner, hazards identified in the annual report described in paragraph (5) that the employer creates or controls.

(iv) Reporting, incident response, and post-incident investigation procedures, including procedures—

(I) for employees to report to the employer workplace violence risks, hazards, and incidents;

(II) for employers to respond to reports of workplace violence;

(III) for employers to perform a post-incident investigation and debriefing of all reports of workplace violence with the participation of employees and their representatives; and

(IV) to provide medical care or first aid to affected employees.

(v) Procedures for emergency response, including procedures for threats of mass casualties and procedures for incidents involving a firearm or a dangerous weapon.

(vi) Procedures for communicating with and educating of covered employees on workplace violence hazards, threats, and work practice controls, the employer's plan, and procedures for confronting, responding to, and reporting workplace violence threats, incidents, and concerns, and employee rights.

(vii) Procedures for ensuring the coordination of risk assessment efforts, Plan development, and implementation of the Plan with other employers who have employees who work at the covered facility or who are performing the covered service.

(viii) Procedures for conducting the annual evaluation under paragraph (6).

(C) AVAILABILITY OF PLAN.—Each Plan shall be made available at all times to the covered employees who are covered under such Plan.

(D) CLARIFICATION.—The requirement under subparagraph (A)(i) shall not be construed to require that all direct care employees and employee representatives participate in the development and implementation of the Plan.

(2) VIOLENT INCIDENT INVESTIGATION.—

(A) IN GENERAL.—As soon as practicable after a workplace violence incident, of which a covered employer has knowledge, the employer shall conduct an investigation of such incident, under which the employer shall—

(i) review the circumstances of the incident and whether any controls or measures implemented pursuant to the Plan of the employer were effective; and

(ii) solicit input from involved employees, their representatives, and supervisors, about the cause of the incident, and whether further corrective measures (including system-level factors) could have prevented the incident, risk, or hazard.

(B) DOCUMENTATION.—A covered employer shall document the findings, recommendations, and corrective measures taken for each investigation conducted under this paragraph.

(3) EDUCATION.—With respect to the covered employees covered under a Plan of a covered employer, the employer shall provide education to such employees who may be exposed to workplace violence hazards and risks, which meet the following requirements:

(A) Annual education includes information on the Plan, including identified workplace violence hazards, work practice control measures, reporting procedures, record keeping requirements, response procedures, and employee rights.

(B) Additional hazard recognition education for supervisors and managers to ensure they can recognize high-risk situations and do not assign employees to situations that predictably compromise their safety.

(C) Additional education for each such covered employee whose job circumstances has changed, within a reasonable timeframe after such change.

(D) Applicable new employee education prior to employee's job assignment.

(E) All education provides such employees opportunities to ask questions, give feedback on such education, and request additional instruction, clarification, or other followup.

(F) All education is provided in-person or online and by an individual with knowledge of workplace violence prevention and of the Plan.

(G) All education is appropriate in content and vocabulary to the language, educational level, and literacy of such covered employees.

(4) RECORDKEEPING AND ACCESS TO PLAN RECORDS.—

(A) IN GENERAL.—Each covered employer shall—

(i) maintain at all times records related to each Plan of the employer, including workplace violence risk and hazard assessments, and identification, evaluation, correction, and education procedures;

(ii) maintain for a minimum of 5 years—

(I) a violent incident log described in subparagraph (B) for recording all workplace violence incidents; and

(II) records of all incident investigations as required under paragraph (2)(B); and

(iii) make such records and logs available, upon request, to covered employees and their representatives for examination and copying in accordance with section 1910.1020 of title 29, Code of Federal Regulations (as such section is in effect on the date of enactment of this Act), and in a manner consistent with HIPAA privacy regulations (defined in section 1180(b)(3) of the Social Security Act (42 U.S.C. 1320d–9(b)(3))) and part 2 of title 42, Code of Federal Regulations (as such part is in effect on the date of enactment of this part), and ensure that any such records and logs removed from the employer's control for purposes of this clause omit any element of personal identifying information sufficient to allow identification of any patient, resident, client, or other individual alleged to have committed a violent incident (including the person's name, address, electronic mail address, telephone number, or social security number, or other information that, alone or in combination with other publicly available information, reveals such person's identity).

(B) VIOLENT INCIDENT LOG DESCRIPTION.—Each violent incident log—

(i) shall be maintained by a covered employer for each covered facility controlled by the employer and for each covered service being performed by a covered employee on behalf of such employer;

(ii) may be based on a template developed by the Secretary not later than 1 year after the date of promulgation of the standards under section 101(a);

(iii) may include a description of—

(I) the violent incident (including environmental risk factors present at the time of the incident);

(II) the date, time, and location of the incident, names and job titles of involved employees;

(III) the nature and extent of injuries to covered employees;

(IV) a classification of the perpetrator who committed the violence, including whether the perpetrator was—

(aa) a patient, client, resident, or customer of a covered employer;

(bb) a family or friend of a patient, client, resident, or customer of a covered employer;

(cc) a stranger;

(dd) a coworker, supervisor, or manager of a covered employee;

(ee) a partner, spouse, parent, or relative of a covered employee; or

(ff) any other appropriate classification;

(V) the type of violent incident (such as type 1 violence, type 2 violence, type 3 violence, or type 4 violence); and

(VI) how the incident was addressed;

(iv) not later than 7 days, depending on the availability or condition of the witness, after the employer learns of such incident, shall contain a record of each violent incident, which is updated to ensure completeness of such record;

(v) shall be maintained for not less than 5 years; and

(vi) in the case of a violent incident involving a privacy concern case as defined in section 1904.29(b)(7) of title 29, Code of Federal Regulations (as such section is in effect on the date of enactment of this Act), shall protect the identity of employees in a manner consistent with that section.

(C) ANNUAL SUMMARY.—Each covered employer shall prepare an annual summary of each violent incident log for the preceding calendar year that shall—

(i) with respect to each covered facility, and each covered service, for which such a log has been maintained, include the total number of violent incidents, the number of recordable injuries related to such incidents, and the total number of hours worked by the covered employees for such preceding year;

(ii) be completed on a form provided by the Secretary;

(iii) be posted for three months beginning February 1 of each year in a manner consistent with the requirements of section 1904 of title 29, Code of Federal Regulations (as such section is in effect on the date of enactment of this Act), relating to the posting of summaries of injury and illness logs;

(iv) be located in a conspicuous place or places where notices to employees are customarily posted; and

(v) not be altered, defaced, or covered by other material by the employer.

(5) ANNUAL EVALUATION.—Each covered employer shall conduct an annual written evaluation, conducted with the full, active participation of covered employees and employee representatives, of—

(A) the implementation and effectiveness of the Plan, including a review of the violent incident log; and

(B) compliance with education required by each standard described in section 101, and specified in the Plan.

(6) ANTI-RETALIATION.—

(A) POLICY.—Each covered employer shall adopt a policy prohibiting any person (including an agent of the employer) from discriminating or retaliating against any employee for reporting, or seeking assistance or intervention from, a workplace violence incident, threat, or concern to the employer, law enforcement, local emergency services, or a government agency, or participating in an incident investigation.

(B) ENFORCEMENT.—Each violation of the policy shall be enforced in the same manner and to the same extent as a violation of section 11(c) of the Occupational Safety and Health Act (29 U.S.C. 660(c)) is enforced.

SEC. 104. RULES OF CONSTRUCTION.

Notwithstanding section 18 of the Occupational Safety and Health Act of 1970 (29 U.S.C. 667)—

(1) nothing in this title shall be construed to curtail or limit authority of the Secretary under any other provision of the law;

(2) the rights, privileges, or remedies of covered employees shall be in addition to the rights, privileges, or remedies provided under any Federal or State law, or any collective bargaining agreement; and

(3) nothing in this Act shall be construed to limit or prevent health care workers, social service workers, or other personnel from reporting violent incidents to appropriate law enforcement.

SEC. 105. OTHER DEFINITIONS.

In this title:

(1) WORKPLACE VIOLENCE.—

(A) IN GENERAL.—The term ''workplace violence'' means any act of violence or threat of violence, that occurs at a covered facility or while a covered employee performs a covered service.

(B) EXCLUSIONS.—The term ''workplace violence'' does not include lawful acts of self-defense or lawful acts of defense of others.

(C) INCLUSIONS.—The term ''workplace violence'' includes an incident involving the threat or use of a firearm or a dangerous weapon, including the use of common objects as weapons, without regard to whether the employee sustains an injury.

(2) TYPE 1 VIOLENCE.—The term ''type 1 violence''—

(A) means workplace violence directed at a covered employee at a covered facility or while performing a covered service by an individual who has no legitimate business at the covered facility or with respect to such covered service; and

(B) includes violent acts by any individual who enters the covered facility or worksite where a covered service is being performed with the intent to commit a crime.

(3) TYPE 2 VIOLENCE.—The term ''type 2 violence'' means workplace violence directed at a covered employee by customers, clients, patients, students, inmates, or any individual for whom a covered facility provides services or for whom the employee performs covered services.

(4) TYPE 3 VIOLENCE.—The term ''type 3 violence'' means workplace violence directed at a covered employee by a present or former employee, supervisor, or manager.

(5) TYPE 4 VIOLENCE.—The term ''type 4 violence'' means workplace violence directed at a covered employee by an individual who is not an employee, but has or is known to have had a personal relationship with such employee.

(6) ALARM.—The term ''alarm'' means a mechanical, electrical, or electronic device that can alert others but does not rely upon an employee's vocalization in order to alert others.

(7) ENGINEERING CONTROLS.—

(A) IN GENERAL.—The term ''engineering controls'' means an aspect of the built space or a device that removes or minimizes a hazard from the workplace or creates a barrier between a covered employee and the hazard.

(B) INCLUSIONS.—For purposes of reducing workplace violence hazards, the term ''engineering controls'' includes electronic access controls to employee occupied areas, weapon detectors (installed or handheld), enclosed workstations with shatter-resistant glass, deep service counters, separate rooms or areas for high-risk patients, locks on doors, removing access to or securing items that could be used as weapons, furniture affixed to the floor, opaque glass in patient rooms (which protects privacy, but allows the health care provider to see where the patient is before entering the room), closed-circuit television monitoring and video recording, sight-aids, and personal alarm devices.

(8) ENVIRONMENTAL RISK FACTORS.—

(A) IN GENERAL.—The term ''environmental risk factors'' means factors in the covered facility or area in which a covered service is performed that may contribute to the likelihood or severity of a workplace violence incident.

(B) CLARIFICATION.—Environmental risk factors may be associated with the specific task being performed or the work area, such as working in an isolated area, poor illumination or blocked visibility, and lack of physical barriers between individuals and persons at risk of committing workplace violence.

(9) PATIENT-SPECIFIC RISK FACTORS.—The term ''patient-specific risk factors'' means factors specific to a patient that may increase the likelihood or severity of a workplace violence incident, including—

(A) a patient's psychiatric condition, treatment and medication status, history of violence, and known or recorded use of drugs or alcohol; and

(B) any conditions or disease processes of the patient that may cause the patient to experience confusion or disorientation, to be non-responsive to instruction, or to behave unpredictably.

(10) SECRETARY.—The term ''Secretary'' means the Secretary of Labor.

(11) WORK PRACTICE CONTROLS.—

(A) IN GENERAL.—The term ''work practice controls'' means procedures and rules that are used to effectively reduce workplace violence hazards.

(B) INCLUSIONS.—The term ''work practice controls'' includes assigning and placing sufficient numbers of staff to reduce patient-specific Type 2 workplace violence hazards, provision of dedicated and available safety personnel such as security guards, employee training on workplace violence prevention method and techniques to de-escalate and minimize violent behavior, and employee education on procedures for response in the event of a workplace violence incident and for post-incident response.

TITLE II—AMENDMENTS TO THE SOCIAL SECURITY ACT

SEC. 201. APPLICATION OF THE WORKPLACE VIOLENCE PREVENTION STANDARD TO CERTAIN FACILITIES RECEIVING MEDICARE FUNDS.

(a) IN GENERAL.—Section 1866 of the Social Security Act (42 U.S.C. 1395cc) is amended—

(1) in subsection (a)(1)—

(A) in subparagraph (X), by striking ''and'' at the end;

(B) in subparagraph (Y), by striking at the end the period and inserting ''; and''; and

(C) by inserting after subparagraph (Y) the following new subparagraph:

''(Z) in the case of hospitals that are not otherwise subject to the Occupational Safety and Health Act of 1970 (or a State occupational safety and health plan that is approved under 18(b) of such Act) and skilled nursing facilities that are not otherwise subject to such Act (or such a State occupational safety and health plan), to comply with the Workplace Violence Prevention Standard (as promulgated under section 101 of the Workplace Violence Prevention for Health Care and Social Service Workers Act).''; and

(2) in subsection (b)(4)—

(A) in subparagraph (A), by inserting ''and a hospital or skilled nursing facility that fails to comply with the requirement of subsection (a)(1)(Z) (relating to the Workplace Violence Prevention Standard)'' after ''Bloodborne Pathogens Standard)''; and

(B) in subparagraph (B)—

(i) by striking ''(a)(1)(U)'' and inserting ''(a)(1)(V)''; and

(ii) by inserting ''(or, in the case of a failure to comply with the requirement of subsection (a)(1)(Z), for a violation of the Workplace Violence Prevention standard referred to in such subsection by a hospital or skilled nursing facility, as applicable, that is subject to the provisions of such Act)'' before the period at the end.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply beginning on the date that is 1 year after the date of issuance of the final standard on workplace violence prevention required under section 101.

The SPEAKER pro tempore. Pursuant to House Resolution 303, the gentleman from Pennsylvania (Mr. KELLER) and a Member opposed each will control 5 minutes.

The Chair recognizes the gentleman from Pennsylvania.

Mr. KELLER. Madam Speaker, I yield myself such time as I may consume.

Madam Speaker, I rise today in support of this amendment, which I am offering with my colleague, Representative WALBERG.

Healthcare and social service workers face real safety risks in the workplace. This issue demands our attention and thoughtful consideration.

Unfortunately, H.R. 1195 will result in a rushed and flawed OSHA rule that will not effectively address workplace violence. This bill is excessively prescriptive and heavy-handed, prejudging and imposing a regulation without allowing for necessary stakeholder input and expert review.

Just as Members of Congress should be working together to develop adequate solutions to these pressing issues, OSHA should be working with and listening to industry experts and stakeholders closest to the problem.

That is why this amendment requires OSHA to follow proper procedures in their rulemaking process, including inviting meaningful stakeholder participation, and responding to comments from the public.

The amendment also calls on OSHA to convene the already planned Small Business Regulatory Enforcement Fairness Act panel before proceeding with the rulemaking process.

This will ensure that small employers directly impacted by the rule have the chance to speak on it, allowing for a more informed solution that empowers workers and employers, not one that cripples them with overbearing Federal mandates

This amendment would also require OSHA to conduct an educational campaign on workplace violence prevention in healthcare and social services industries.

This initiative would target the regulated community and raise awareness of the issue while also increasing compliance with the eventual final rule.

Finally, despite the heavy burdens placed on our healthcare system responding to the pandemic, the Biden administration is considering a job-killing emergency, temporary standard on COVID–19 that will further bog down already overwhelmed businesses with sweeping and costly mandates at the very time that vaccines are widely available and the economy is recovering at a record pace.

As such, this amendment removes the unnecessary and problematic requirement that OSHA issue an interim final standard on workplace violence within 1 year, enabling these facilities to continue fighting COVID–19 and allowing our entire economy to continue recovering from economic peril.

We all agree that our frontline workers have shown incredible courage in responding to this global health crisis and their efforts continue to be an invaluable part of our Nation's recovery.

We owe it to these heroes to provide a solution that keeps them safe at work without drowning employers in compliance costs or implementing overbearing rules and rushed regulations from Washington that do not take into account their meaningful input.

We owe these frontline workers the opportunity to have their say and their input. This amendment does just that, and I urge my colleagues to support it. Madam Speaker, I yield back the balance of my time.

Mr. COURTNEY. Madam Speaker, I rise in opposition to the amendment.

The SPEAKER pro tempore. The gentleman from Connecticut is recognized for 5 minutes.

Mr. COURTNEY. Madam Speaker, I again want to clarify for the record that Congress in the past has required interim standards in situations where there have been real acute problems in America's workforce. We did it for workers who were working in hazardous waste and hazardous disposal sites, and we did it for workers who were exposed to lead.

So, again, there is precedent for this. This is not having an interim standard where there is an urgent need to have some action for just a program standard for workers out there. We have done it in the past. And I think we have certainly heard enough from the other side that they acknowledge the severity of the problem and the incredible people that would benefit from having a standard out there that we should apply the interim rule in this case, which would take place a year from enactment and then the final standard 3½ years from enactment.

I want to be clear. When we drafted the bill, we put in language that requires a notice and comment section for both the interim standard and the final standard. Nobody is being foreclosed in terms of having an opportunity to weigh in.

Since 1996, OSHA has had voluntary recommendations and guidelines for workplace safety in healthcare settings. This thing has been knocking around for 25 years, and that is no secret here. We are not starting from a blank sheet of paper.

So, again, all the stakeholders know what some of the strategies are that could be employed to protect workers better, and what we are doing in the baseline of the bill is basically saying we are not going to sit back and let the dysfunctional history of OSHA dominate and really expose people needlessly to workplace violence.

Again, Mr. SCOTT went through the sad history over OSHA: 18 years for beryllium; 17 years for silica dust; 16 or 17 years for working in enclosed construction site spaces. OSHA is just notorious in terms of going slow, and, in fact, the last administration, which did try to convene the Small Business panel, postponed it five separate times, and today there is nothing scheduled. I mean, zero.

So, again, I appreciate the fact that the other side acknowledges the seriousness of the problem. Again, I think the bill acts on that by actually putting a clock on OSHA to move forward.

I will close by saying that the administration has weighed in, who actually is the executive branch that has control of OSHA, and, again, they submitted a letter titled: ''Statement of

Administration Policy'' on April 13 supporting this bill, and specifically the 1-year interim standard and the 42-month final standard timeline that is in the bill. I include that letter in the RECORD, Madam Speaker.

STATEMENT OF ADMINISTRATION POLICY

H.R. 1195—WORKPLACE VIOLENCE PREVENTION FOR HEALTH CARE AND SOCIAL SERVICE WORKERS ACT—REP. COURTNEY, D–CT, AND 145 COSPONSORS

The Administration strongly supports passage of H.R. 1195, the Workplace Violence Prevention for Health Care and Social Service Workers Act. This bipartisan legislation will lead to the development of Federal standards to ensure that health care and social service employers develop and implement plans to protect their staff, prevent and improve the response to workplace violence, and address existing barriers to reporting.

Even before the COVID–19 pandemic, incidents of violence against health care and social service workers have been on the rise. A 2016 Government Accountability Office study reported that rates of violence against health care workers are up to 12 times higher than rates for the overall workforce. In 2018, the Bureau of Labor Statistics reported that health care and social service workers were nearly five times as likely to suffer a serious workplace violence injury than workers in other sectors, and that healthcare workers accounted for 73 percent of such injuries. In 2017, state government health care and social service workers were almost nine times more likely to be injured by an assault than private-sector health care workers. Front line employees in these settings interact with a range of patients, clients, and their families, often with little training or direction for how to handle interactions that may become violent. Workplace violence often causes both physical and emotional harm. Victims of these incidents often suffer post-traumatic stress that undermines their ability to continue their employment in that sector. This burdens a stretched health care workforce that has been severely impacted by the COVID–19 pandemic. There is currently no Occupational Safety and Health Administration (OSHA) standard that requires employers to implement violence prevention plans that would help reduce workplace violence injuries among health care and social service workers.

Under the Workplace Violence Prevention for Health Care and Social Service Workers Act, OSHA must issue an interim final standard in one year and a final standard within 42 months requiring employers in the health care and social service sectors to develop and implement a workplace violence prevention plan. Under such a standard, employers would need to ensure that health care and social service workers are directly involved in the development, implementation, and assessment of these plans. This will include identifying risks, specifying solutions, and requiring training, reporting, and incident investigations. It would also provide protections from retaliation for reporting violent incidents. Additionally, this legislation will protect health care and social service workers in the public sector in 24 states where those employees are not covered by OSHA protections.

The Administration commends the bipartisan support for the Workplace Violence Prevention for Health Care and Social Service Workers Act and urges swift passage of this legislation.

Mr. COURTNEY. Madam Speaker, respectfully I rise in opposition and recommend a ''no'' vote on Mr. KELLER's amendment, and I yield back the balance of my time.

The SPEAKER pro tempore. Pursuant to House Resolution 303, the previous question is ordered on the amendment offered by the gentleman from Pennsylvania (Mr. KELLER).

The question is on the amendment.

The question was taken; and the Speaker pro tempore announced that the noes appear to have it.

Mr. KELLER. Madam Speaker, on that I demand the yeas and nays.

The SPEAKER pro tempore. Pursuant to section 3(s) of House Resolution 8, the yeas and nays are ordered.

The vote was taken by electronic device, and there were—yeas 168, nays 256, not voting 5, as follows:

[Roll No. 117]

YEAS—168

Aderholt	Grothman	Mullin
Allen	Guest	Murphy (NC)
Amodei	Guthrie	Nehls
Armstrong	Hagedorn	Newhouse
Babin	Harris	Norman
Baird	Harshbarger	Nunes
Balderson	Hartzler	Obernolte
Banks	Hern	Owens
Barr	Herrera Beutler	Palazzo
Bentz	Higgins (LA)	Palmer
Bergman	Hill	Pence
Bice (OK)	Hinson	Pfluger
Bilirakis	Hollingsworth	Reed
Bishop (NC)	Hudson	Reschenthaler
Bost	Huizenga	Rice (SC)
Brady	Issa	Rodgers (WA)
Buchanan	Jackson	Rogers (AL)
Bucshon	Jacobs (NY)	Rogers (KY)
Burgess	Johnson (LA)	Rose
Calvert	Johnson (OH)	Rouzer
Carl	Johnson (SD)	Rutherford
Carter (GA)	Jordan	Salazar
Carter (TX)	Joyce (OH)	Scalise
Chabot	Joyce (PA)	Schweikert
Cheney	Keller	Scott, Austin
Cline	Kelly (MS)	Sessions
Cloud	Kelly (PA)	Simpson
Cole	Kim (CA)	Smith (MO)
Comer	Kinzinger	Smith (NE)
Crawford	Kustoff	Smucker
Crenshaw	LaHood	Spartz
Curtis	LaMalfa	Steel
Davis, Rodney	Lamborn	Stefanik
DesJarlais	Latta	Steil
Diaz-Balart	LaTurner	Steube
Duncan	Lesko	Stewart
Dunn	Letlow	Taylor
Emmer	Long	Tenney
Estes	Loudermilk	Thompson (PA)
Fallon	Lucas	Timmons
Feenstra	Luetkemeyer	Turner
Ferguson	Malliotakis	Upton
Fischbach	Mann	Valadao
Fitzgerald	McCarthy	Van Duyne
Fleischmann	McCaul	Wagner
Foxx	McClain	Walberg
Fulcher	McHenry	Walorski
Gallagher	McKinley	Waltz
Garbarino	Meijer	Weber (TX)
Gimenez	Meuser	Wenstrup
Gonzales, Tony	Miller (WV)	Williams (TX)
Gonzalez (OH)	Miller-Meeks	Wilson (SC)
Granger	Moolenaar	Wittman
Graves (LA)	Mooney	Womack
Graves (MO)	Moore (AL)	Young
Griffith	Moore (UT)	Zeldin

NAYS—256

Adams	Bishop (GA)	Budd
Aguilar	Blumenauer	Burchett
Allred	Blunt Rochester	Bush
Arrington	Boebert	Bustos
Auchincloss	Bonamici	Butterfield
Axne	Bourdeaux	Cammack
Bacon	Bowman	Carbajal
Barragán	Boyle, Brendan F.	Cárdenas
Bass	Brooks	Carson
Beatty	Brown	Cartwright
Bera	Brownley	Case
Beyer	Buck	Casten
Biggs	Castro (TX)	Castor (FL)
Blumenauer	Chu	Castro (TX)
Blunt Rochester	Cicilline	Chu
Boebert	Clark (MA)	Cicilline
Bonamici	Clarke (NY)	Clark (MA)
Bourdeaux	Cleaver	Clarke (NY)
Bowman	Clyburn	Cleaver
Boyle, Brendan F.	Clyde	Clyburn
Brooks	Cohen	Clyde
Brown	Connolly	Cohen
Brownley	Correa	Connolly
Buck	Costa	Correa
Budd	Courtney	Costa
Burchett	Craig	Courtney
Bush	Crist	Craig
Bustos	Crow	Crist
Butterfield	Cuellar	Crow
Cammack	Davids (KS)	Cuellar
Carbajal	Davidson	Davids (KS)
Cárdenas	Davis, Danny K.	Davidson
Carson	Dean	Davis, Danny K.
Cartwright	DeFazio	Dean
Case	DeGette	DeFazio
Casten	DeLauro	DeGette
Castor (FL)	DelBene	DeLauro
Castro (TX)	Delgado	DelBene
Chu	Demings	Delgado
Cicilline	DeSaulnier	Demings
Clark (MA)	Deutch	DeSaulnier
Clarke (NY)	Dingell	Deutch
Cleaver	Doggett	Dingell
Clyburn	Donalds	Doggett
Clyde	Doyle, Michael F.	Donalds
Cohen	Escobar	Doyle, Michael F.
Connolly	Eshoo	Escobar
Correa	Espaillat	Eshoo
Costa	Evans	Espaillat
Courtney	Fitzpatrick	Evans
Craig	Fletcher	Fitzpatrick
Crist	Fortenberry	Fletcher
Crow	Foster	Fortenberry
Cuellar	Frankel, Lois	Foster
Davids (KS)	Gaetz	Frankel, Lois
Davidson	Gallego	Gaetz
Davis, Danny K.	Garamendi	Gallego
Dean	Garcia (CA)	Garamendi
DeFazio	Garcia (IL)	Garcia (CA)
DeGette	Garcia (TX)	Garcia (IL)
DeLauro	Gibbs	Garcia (TX)
DelBene	Gohmert	Gibbs
Delgado	Golden	Gohmert
Demings	Gomez	Golden
DeSaulnier	Gonzalez, Vicente	Gomez
Deutch	Good (VA)	Gonzalez, Vicente
Dingell	Gooden (TX)	Good (VA)
Doggett	Gosar	Gooden (TX)
Donalds	Gottheimer	Gosar
Doyle, Michael F.	Green (TN)	Gottheimer
Escobar	Green, Al (TX)	Green (TN)
Eshoo	Greene (GA)	Green, Al (TX)
Espaillat	Grijalva	Greene (GA)
Evans	Harder (CA)	Grijalva
Fitzpatrick	Hayes	Harder (CA)
Fletcher	Herrell	Hayes
Fortenberry	Hice (GA)	Herrell
Foster	Higgins (NY)	Hice (GA)
Frankel, Lois	Himes	Higgins (NY)
Gaetz	Horsford	Himes
Gallego	Houlahan	Horsford
Garamendi	Hoyer	Houlahan
Garcia (CA)	Huffman	Hoyer
Garcia (IL)	Jackson Lee	Huffman
Garcia (TX)	Jacobs (CA)	Jackson Lee
Gibbs	Jayapal	Jacobs (CA)
Gohmert	Jeffries	Jayapal
Golden	Johnson (GA)	Jeffries
Gomez	Johnson (TX)	Johnson (GA)
Gonzalez, Vicente	Jones	Johnson (TX)
Good (VA)	Kahele	Jones
Gooden (TX)	Kaptur	Kahele
Gosar	Katko	Kaptur
Gottheimer	Keating	Katko
Green (TN)	Kelly (IL)	Keating
Green, Al (TX)	Khanna	Kelly (IL)
Greene (GA)	Kildee	Khanna
Grijalva	Kilmer	Kildee
Harder (CA)	Kim (NJ)	Kilmer
Hayes	Kind	Kim (NJ)
Herrell	Kirkpatrick	Kind
Hice (GA)	Krishnamoorthi	Kirkpatrick
Higgins (NY)	Kuster	Krishnamoorthi
Himes	Lamb	Kuster
Horsford	Langevin	Lamb
Houlahan	Larsen (WA)	Langevin
Hoyer	Larson (CT)	Larsen (WA)
Huffman	Lawrence	Larson (CT)
Jackson Lee	Lawson (FL)	Lawrence
Jacobs (CA)	Lee (CA)	Lawson (FL)
Jayapal	Lee (NV)	Lee (CA)
Jeffries	Leger Fernandez	Lee (NV)
Johnson (GA)	Levin (CA)	Leger Fernandez
Johnson (TX)	Levin (MI)	Levin (CA)
Jones	Lieu	Levin (MI)
Kahele	Lofgren	Lieu
Kaptur	Lowenthal	Lofgren
Katko	Luria	Lowenthal
Keating	Lynch	Luria
Kelly (IL)	Mace	Lynch
Khanna	Malinowski	Mace
Kildee	Maloney, Carolyn B.	Malinowski
Kilmer	Maloney, Sean	Maloney, Carolyn B.
Kim (NJ)	Manning	Maloney, Sean
Kind	Massie	Manning
Kirkpatrick	Mast	Massie
Krishnamoorthi	Matsui	Mast
Kuster	McBath	Matsui
Lamb	McClintock	McBath
Langevin	McCollum	McClintock
Larsen (WA)	McEachin	McCollum
Larson (CT)	McGovern	McEachin
Lawrence	McNerney	McGovern
Lawson (FL)	Meeks	McNerney
Lee (CA)	Meng	Meeks
Lee (NV)	Mfume	Meng
Leger Fernandez	Miller (IL)	Mfume
Levin (CA)	Moore (WI)	Miller (IL)
Levin (MI)	Morelle	Moore (WI)
Lieu	Moulton	Morelle
Lofgren	Mrvan	Moulton
Lowenthal	Murphy (FL)	Mrvan
Luria	Nadler	Murphy (FL)
Lynch	Napolitano	Nadler
Mace	Neal	Napolitano
Malinowski	Neguse	Neal
Maloney, Carolyn B.	Newman	Neguse
Maloney, Sean	Norcross	Newman
Manning	O'Halleran	Norcross
Massie	Ocasio-Cortez	O'Halleran
Mast	Omar	Ocasio-Cortez
Matsui	Pallone	Omar
McBath	Panetta	Pallone
McClintock	Pappas	Panetta
McCollum	Pascrell	Pappas
McEachin	Payne	Pascrell
McGovern	Perlmutter	Payne
McNerney	Perry	Perlmutter
Meeks	Peters	Perry
Meng	Phillips	Peters
Mfume	Pingree	Phillips
Miller (IL)	Pocan	Pingree
Moore (WI)	Porter	Pocan
Morelle	Posey	Porter
Moulton	Pressley	Posey
Mrvan	Price (NC)	Pressley
Murphy (FL)	Quigley	Price (NC)
Nadler	Raskin	Quigley
Napolitano	Rice (NY)	Raskin
Neal	Rosendale	Rice (NY)
Neguse	Ross	Rosendale
Newman	Roy	Ross
Norcross	Roybal-Allard	Roy
O'Halleran	Ruiz	Roybal-Allard
Ocasio-Cortez	Ruppersberger	Ruiz
Omar	Rush	Ruppersberger
Pallone	Ryan	Rush
Panetta	Sánchez	Ryan
Pappas	Sarbanes	Sánchez
Pascrell	Scanlon	Sarbanes
Payne	Schakowsky	Scanlon
Perlmutter	Schiff	Schakowsky
Perry	Schneider	Schiff
Peters	Schrader	Schneider
Phillips	Schrier	Schrader
Pingree	Scott (VA)	Schrier
Pocan	Scott, David	Scott (VA)
Porter	Sewell	Scott, David
Posey	Sherman	Sewell
Pressley	Sherrill	Sherman
Price (NC)	Sires	Sherrill
Quigley	Slotkin	Sires
Raskin	Smith (NJ)	Slotkin
Rice (NY)	Smith (WA)	Smith (NJ)
Rosendale	Soto	Smith (WA)
Ross	Spanberger	Soto
Roy	Speier	Spanberger
Roybal-Allard	Stanton	Speier
Ruiz	Stauber	Stanton
Ruppersberger	Stevens	Stauber
Rush	Strickland	Stevens
Ryan	Suozzi	Strickland
Sánchez	Swalwell	Suozzi
Sarbanes	Takano	Swalwell
Scanlon	Thompson (CA)	Takano
Schakowsky	Thompson (MS)	Thompson (CA)
Schiff	Tiffany	Thompson (MS)
Schneider	Titus	Tiffany
Schrader	Tlaib	Titus
Schrier	Tonko	Tlaib
Scott (VA)	Torres (CA)	Tonko
Scott, David	Torres (NY)	Torres (CA)
Sewell	Trahan	Torres (NY)
Sherman	Trone	Trahan
Sherrill	Underwood	Trone
Sires	Van Drew	Underwood
Slotkin	Vargas	Van Drew
Smith (NJ)	Veasey	Vargas
Smith (WA)	Vela	Veasey
Soto	Velázquez	Vela
Spanberger	Wasserman Schultz	Velázquez
Speier	Waters	Wasserman Schultz
Stanton	Watson Coleman	Waters
Stauber	Welch	Watson Coleman
Stevens	Westerman	Welch
Strickland	Wexton	Westerman
Suozzi	Wild	Wexton
Swalwell	Williams (GA)	Wild
Takano	Wilson (FL)	Williams (GA)
Thompson (CA)	Yarmuth	Wilson (FL)
Thompson (MS)		Yarmuth
Tiffany		
Titus		
Tlaib		
Tonko		
Torres (CA)		
Torres (NY)		
Trahan		
Trone		
Underwood		
Van Drew		
Vargas		
Veasey		
Vela		
Velázquez		
Wasserman Schultz		
Waters		
Watson Coleman		
Welch		
Westerman		
Wexton		
Wild		
Williams (GA)		
Wilson (FL)		
Yarmuth		

NOT VOTING—5

Cawthorn	Franklin, C. Scott	Stivers
Cooper		Webster (FL)

□ 1116

Messrs. KIND, WESTERMAN, DeSAULNIER, Mrs. TORRES of California, Messrs. GIBBS, GOODEN of Texas, Ms. LEGER FERNANDEZ, Messrs. COSTA, CLYDE, GOHMERT, and MAST changed their vote from ''yea'' to ''nay.''

Mr. OWENS, Ms. CHENEY, and Mr. BANKS changed their vote from ''nay'' to ''yea.''

So the amendment was rejected.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

MEMBERS RECORDED PURSUANT TO HOUSE RESOLUTION 8, 117TH CONGRESS

Allred (Wexton)
Babin (Fallon)
Barragán (Beyer)
Buchanan (LaHood)
Cárdenas (Gonzalez, Vicente)
Crenshaw (Fallon)
Gomez (Pressley)
Gottheimer (Panetta)
Graves (MO) (Wagner)
Greene (GA) (Gosar)
Grijalva (García (IL))
Jayapal (Pocan)
Johnson (TX) (Jeffries)
Keating (Clark (MA))
Lawrence (Kildee)
Lawson (FL) (Evans)
Lieu (Beyer)
Lowenthal (Beyer)
McHenry (Banks)
Meng (Clark (MA))
Mfume (Wexton)
Moore (WI) (Beyer)
Moulton (Underwood)
Napolitano (Correa)
Neal (Lynch)
Nehls (Fallon)
Norcross (Pallone)
Omar (Pressley)
Payne (Pallone)
Porter (Wexton)
Rush (Underwood)
Sewell (DelBene)
Sires (Pallone)
Stefanik (Tenney)
Steube (Timmons)
Trahan (Lynch)
Walorski (Wagner)
Wasserman Schultz (Soto)
Watson Coleman (Pallone)
Wilson (FL) (Hayes)
Wilson (SC) (Timmons)

The SPEAKER pro tempore. The previous question is ordered on the bill, as amended.

The question is on the engrossment and third reading of the bill.

The bill was ordered to be engrossed and read a third time, and was read the third time.

The SPEAKER pro tempore. The question is on the passage of the bill.

The question was taken; and the Speaker pro tempore announced that the noes appeared to have it.

Mr. SCOTT of Virginia. Madam Speaker, on that I demand the yeas and nays.

The SPEAKER pro tempore. Pursuant to section 3(s) of House Resolution 8, the yeas and nays are ordered.

The vote was taken by electronic device, and there were—yeas 254, nays 166, not voting 9, as follows:

[Roll No. 118]

YEAS—254

Adams
Aguilar
Allred
Auchincloss
Axne
Bacon
Barragán
Bass
Beatty
Bera
Beyer
Bishop (GA)
Blumenauer
Blunt Rochester
Bonamici
Bost
Bourdeaux
Bowman
Boyle, Brendan F.
Brady
Brown
Brownley
Bucshon
Bush
Bustos
Butterfield
Carbajal
Cárdenas
Carson
Cartwright
Case
Casten
Castor (FL)
Castro (TX)
Chu
Cicilline
Clark (MA)
Clarke (NY)
Cleaver
Clyburn
Cohen
Cole
Connolly
Cooper
Correa
Costa
Courtney
Craig
Crist
Crow
Cuellar
Davids (KS)
Davis, Danny K.
Davis, Rodney
Dean
DeFazio
DeGette
DeLauro
DelBene
Delgado
Demings
DeSaulnier
Deutch
Dingell
Doggett
Doyle, Michael F.
Escobar
Eshoo
Espaillat
Evans
Fitzpatrick
Fletcher
Fortenberry
Foster
Frankel, Lois
Gallego
Garamendi
Garbarino
Garcia (CA)
García (IL)
Garcia (TX)
Gimenez
Golden
Gomez
Gonzalez (OH)
Gonzalez, Vicente
Gottheimer
Graves (LA)
Green, Al (TX)
Griffith
Grijalva
Harder (CA)
Hartzler
Hayes
Herrera Beutler
Higgins (NY)
Himes
Horsford
Houlahan
Hoyer
Huffman
Jackson Lee
Jacobs (CA)
Jacobs (NY)
Jayapal
Jeffries
Johnson (GA)
Johnson (TX)
Jones
Joyce (OH)
Kahele
Kaptur
Katko
Keating
Kelly (IL)
Khanna
Kildee
Kilmer
Kim (CA)
Kim (NJ)
Kind
Kinzinger
Kirkpatrick
Krishnamoorthi
Kuster
Lamb
Langevin
Larsen (WA)
Larson (CT)
Lawrence
Lawson (FL)
Lee (CA)
Lee (NV)
Leger Fernandez
Lesko
Levin (CA)
Levin (MI)
Lieu
Lofgren
Lowenthal
Luria
Lynch
Malinowski
Malliotakis
Maloney, Carolyn B.
Maloney, Sean
Manning
Matsui
McBath
McCollum
McEachin
McGovern
McKinley
McNerney
Meeks
Meijer
Meng
Mfume
Moore (WI)
Morelle
Moulton
Murphy (FL)
Murphy (NC)
Nadler
Napolitano
Neal
Neguse
Newhouse
Newman
Norcross
O'Halleran
Ocasio-Cortez
Omar
Pallone
Panetta
Pappas
Pascrell
Payne
Perlmutter
Peters
Phillips
Pingree
Pocan
Porter
Pressley
Price (NC)
Quigley
Raskin
Reed
Rice (NY)
Rice (SC)
Rodgers (WA)
Ross
Roybal-Allard
Ruiz
Ruppersberger
Rush
Ryan
Salazar
Sánchez
Sarbanes
Scanlon
Schakowsky
Schiff
Schneider
Schrader
Schrier
Scott (VA)
Scott, David
Sewell
Sherman
Sherrill
Sires
Slotkin
Smith (NJ)
Smith (WA)
Soto
Spanberger
Speier
Stanton
Stauber
Stefanik
Stevens
Strickland
Suozzi
Swalwell
Takano
Thompson (CA)
Thompson (MS)
Titus
Tlaib
Tonko
Torres (CA)
Torres (NY)
Trahan
Trone
Underwood
Upton
Van Drew
Vargas
Veasey
Vela
Velázquez
Wasserman Schultz
Waters
Watson Coleman
Welch
Wexton
Wild
Williams (GA)
Wilson (FL)
Yarmuth
Young
Zeldin

NAYS—166

Aderholt
Allen
Amodei
Armstrong
Arrington
Babin
Baird
Balderson
Banks
Barr
Bentz
Bergman
Bice (OK)
Biggs
Bilirakis
Bishop (NC)
Brooks
Buchanan
Buck
Budd
Burchett
Calvert
Cammack
Carl
Carter (GA)
Carter (TX)
Chabot
Cheney
Cline
Cloud
Clyde
Comer
Crawford
Crenshaw
Curtis
Davidson
DesJarlais
Diaz-Balart
Donalds
Duncan
Dunn
Emmer
Estes
Fallon
Feenstra
Ferguson
Fischbach
Fitzgerald
Fleischmann
Foxx
Fulcher
Gaetz
Gallagher
Gibbs
Gohmert
Gonzales, Tony
Good (VA)
Gooden (TX)
Gosar
Granger
Graves (MO)
Green (TN)
Greene (GA)
Grothman
Guest
Guthrie
Hagedorn
Harris
Harshbarger
Hern
Herrell
Hice (GA)
Higgins (LA)
Hill
Hinson
Hollingsworth
Hudson
Issa
Jackson
Johnson (LA)
Johnson (OH)
Johnson (SD)
Jordan
Joyce (PA)
Keller
Kelly (MS)
Kelly (PA)
Kustoff
LaHood
LaMalfa
Lamborn
Latta
LaTurner
Letlow
Long
Loudermilk
Lucas
Luetkemeyer
Mace
Mann
Massie
Mast
McCarthy
McCaul
McClain
McClintock
McHenry
Meuser
Miller (WV)
Miller-Meeks
Moolenaar
Mooney
Moore (AL)
Moore (UT)
Mullin
Nehls
Norman
Nunes
Obernolte
Owens
Palazzo
Palmer
Pence
Perry
Pfluger
Posey
Reschenthaler
Rogers (AL)
Rogers (KY)
Rose
Rosendale
Rouzer
Roy
Rutherford
Scalise
Schweikert
Scott, Austin
Sessions
Simpson
Smith (MO)
Smith (NE)
Smucker
Spartz
Steel
Steil
Steube
Stewart
Taylor
Tenney
Thompson (PA)
Tiffany
Timmons
Turner
Valadao
Van Duyne
Wagner
Walberg
Walorski
Waltz
Weber (TX)
Wenstrup
Westerman
Williams (TX)
Wilson (SC)
Wittman
Womack

NOT VOTING—9

Boebert
Burgess
Cawthorn
Franklin, C. Scott
Huizenga
Miller (IL)
Mrvan
Stivers
Webster (FL)

□ 1148

Mr. COMER changed his vote from ''yea'' to ''nay.''

Messrs. RICE of South Carolina and KIM of New Jersey changed their vote from ''nay'' to ''yea.''

So the bill was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

Stated for:

Mr. MRVAN. Mr. Speaker, had I been present, I would have voted "yea" on rollcall No. 118.

MEMBERS RECORDED PURSUANT TO HOUSE RESOLUTION 8, 117TH CONGRESS

Allred (Wexton)
Babin (Fallon)
Barragán (Beyer)
Buchanan (LaHood)
Cárdenas (Gonzalez, Vicente)
Crenshaw (Fallon)
Gomez (Pressley)
Gottheimer (Panetta)
Graves (MO) (Wagner)
Greene (GA) (Gosar)
Grijalva (García (IL))
Jayapal (Pocan)
Johnson (TX) (Jeffries)
Keating (Clark (MA))
Lawrence (Kildee)
Lawson (FL) (Evans)
Lieu (Beyer)
Lowenthal (Beyer)
McHenry (Banks)
Meng (Clark (MA))
Mfume (Wexton)
Moore (WI) (Beyer)
Moulton (Underwood)
Napolitano (Correa)
Neal (Lynch)
Nehls (Fallon)
Norcross (Pallone)
Omar (Pressley)
Payne (Pallone)
Porter (Wexton)
Rush (Underwood)
Sewell (DelBene)
Sires (Pallone)
Stefanik (Tenney)
Steube (Timmons)
Trahan (Lynch)
Walorski (Wagner)
Wasserman Schultz (Soto)
Watson Coleman (Pallone)
Wilson (FL) (Hayes)
Wilson (SC) (Timmons)

504 CREDIT RISK MANAGEMENT IMPROVEMENT ACT OF 2021

The SPEAKER pro tempore (Mr. CUELLAR). Pursuant to clause 8 of rule XX, the unfinished business is the vote on the motion to suspend the rules and pass the bill (H.R. 1482) to amend the Small Business Act to enhance the Office of Credit Risk Management, to require the Administrator of the Small Business Administration to issue rules relating to environmental obligations of certified development companies, and for other purposes, on which the yeas and nays were ordered.

The Clerk read the title of the bill.

The SPEAKER pro tempore. The question is on the motion offered by the gentlewoman from Kansas (Ms. DAVIDS) that the House suspend the rules and pass the bill.

The vote was taken by electronic device, and there were—yeas 411, nays 8, not voting 10, as follows:

[Roll No. 119]

YEAS—411

Adams
Aderholt
Aguilar
Allen
Allred
Amodei
Armstrong
Arrington
Auchincloss
Axne
Babin
Bacon
Baird
Balderson
Banks
Barr
Barragán
Bass